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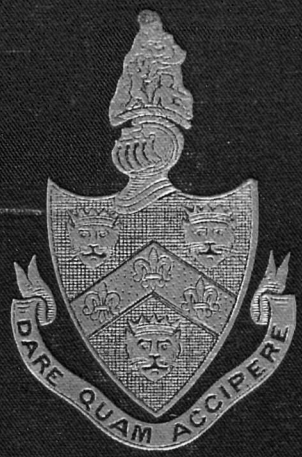

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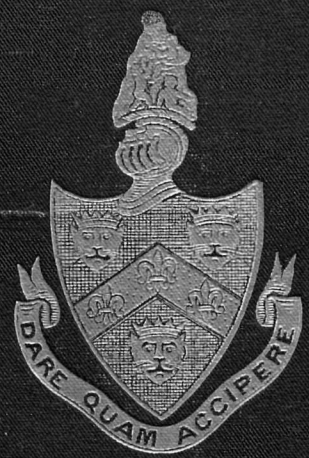

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GUY'S HOSPITAL GAZETTE.

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Passim.

WITH the advent of the New Year the Hospital has regained its normal appearance, and work is once more the order of the day, after a week of Concerts, Christmas Trees, and other Festivities. At first the wards looked strangely bare, stripped of the beautiful decorations which we had almost come to regard as a fixture; while the absence of pianos from the wards, and the return of many of the children, kept at the Hospital for Christmas, to their homes, testified to the re-establishment of working conditions. With a regretful, if somewhat satiated sigh, we doff the mummer's mask and proceed once more to earn our living by the sweat of our brow.

We suppose that the patients enjoyed the entertainments as much as anybody. Certainly it was worth while to see the happy faces of the children at the various concerts, and to watch their ecstatic appreciation of the comedians. From the remarks overheard during the performance we gather that the adults as well thoroughly appreciated the efforts made to amuse them. To appropriate the words used by Kipling with reference to quite a different matter—this was an affair for "Kiddies and grown-ups too-oo-oo."

We congratulate Messrs. Doherty and O'Meara on the success of their Nigger Troupe. The costumes and songs were well-chosen, the gagging inimitable, and the marching song with which they moved from ward to ward an attractive one—though to this day we have not met anyone (not being a Nigger) who can remember the tune of it! Our captious critic makes a few observations in this issue upon the subject of the jokes, which, as he says, were mainly of the "Do you know Jerry?—Jerry who?" order. This may not be the highest form of humour, but it undoubtedly went down well. Perhaps this success was due rather to the cleverness of the performers than to any intrinsic excellence of the gags selected.

From the point of view of unadulterated noisy enjoyment, the cream of the whole "Niggers" programme was their performance at the Landon Out-Patients' Tea. To see 700 Borough Children all enjoying themselves to the top of their bent, and lustily shouting the choruses, was a sight which appealed irresistibly to the child which is in us all. The Niggers, after starting the choruses, left the platform and went in and out among the children, encouraging and prompting the singers, and here and there lifting up a child and carrying him about. When they left, their marching chorus was drowned by 700 young voices shouting "Guy's patients never die."

The Ward Concerts, taken as a whole, were excellent, and much credit is due to those who arranged them and provided the teas. Reports of these concerts will be found in the succeeding pages.

We have one small grievance to record. Why should that enjoyable function, the Out-Patients' Dance, be stopped at so early an hour as 10 p.m.? On the Wednesday of Christmas week a most excellent dance took place in the Out-Patients' Department. A goodly company of students and nurses was present, music was provided by the "Cosmopolitan Five," a tasty supper was arranged by Sister Out-Patients, and the dance was in every way a success. But surely it would be possible to waive the regulations for once, or at any rate to stretch them a little, and allow the dance to continue a little longer.

With regard to New Year Festivities, there is little to say. The dance in the Nurses' Home took place on New Year's Eve, pleasantly concluding the celebrations of the week. We have heard that a number of our Borough friends assembled outside the Front Gates, in the hopes of witnessing a bonfire, or some other form of welcoming the New Year. But nothing happened, so the crowd dispersed.

We publish on page 5 a letter from a correspondent urging us to issue half-yearly volumes containing reprints of the clinical lectures published in the Gazette. He also suggests that we re-name "Passim." "Ponderous Platitudes" or "Sententious Sayings," he thinks, would be a far more suitable title.

To deal first with his first, and more sensible suggestion, we should like to point out that the lectures are now published in the centre pages of the Gazette, so that, if he desires, he may remove these pages and have them bound. (His craving for a record of the athletic events may be satisfied by cutting out all accounts of sport and pasting them in a scrap-book.) We are inclined, however, to entertain his suggestion as to clinical lectures, and only need an assurance that there will be sufficient support for the scheme. The type, in which the lectures are set, is not retained, so that reproduction would be a more costly process than our correspondent supposes. But we should be glad to hear of any other gentlemen who would like the clinical lectures reprinted and issued in separate form.

As regards "Passim," we recognise that the comic relief provided by it is of an ephemeral nature, and we cannot dare to hope that our correspondent desires a reprint of all our rolling periods and gems of literary effort.

But let him beware. The tone of his letter reveals in him that very fault of which he accuses us. The poor, good gentleman is himself suffering from an attack of *Ponderositas Dolorosa*, that distressing complaint but lately known to psychiatry, for which the only remedy, curiously enough, is an extremely efficient extension of the inferior extremity. It would appear that he is applying to us a therapeutic measure of which he himself is in sore need.

There is still hope for him, however. The more sensible of his two suggestions leads us to suppose that his lesion is not organic.

We are glad to hear that a new Residents' Play is to be produced, and wish those concerned in its production all success. So far we have seen no signs of any undue theatrical activity in the Hospital. No managerial voice issuing instructions to a recalcitrant cast has yet reached our ears. No change in the manner of any of the Residents has yet come to our notice. We have not seen them wandering round with papers, muttering to themselves, in an agonised attempt to master their parts, nor have we observed them declaiming either in the College or in the Park. But it may be that rehearsals are already in progress. Perhaps the scene of bread-throwing which we view in the College Dining Room at night is a practice for some sham battle, some masterpiece of histrionic adaptation. At any rate we must bide our time in patience until the day arrives.

An evening spent in reading through some of the old Residents' Plays is never wasted. The pleasure one derives from it repays one a hundredfold. The topical lyrics and delightful foolery of such plays as "The Spoils of Victory," "Ortocure," and "MacTreth" are

too good to be missed. It is a pity that the war put a stop, for the time being, to the activities of our playwrights. Now they are again at their merry task, and we welcome them.

It has again been brought to our notice that articles of clothing have been lost in the College, in circumstances which can leave no doubt that they have been stolen.

It does not surprise us that our burglarious friend has little difficulty in avoiding discovery. The stands provided for hanging up coats in the College, both on the stairs leading to the Dining Hall, and outside the Smoking Room, are so situated that a quiet appropriation of, say, an overcoat requires no great skill.

The most obvious remedy for such a state of affairs is the institution of a cloak-room. Most other students' clubs have a cloak-room. At the London Hospital, for instance, coats are deposited at the entrance to the Club. In return the depositor is given a brass token, which he surrenders on receiving his coat again.

It would be quite possible for one of the rooms on the ground floor of the College to be converted into a cloak-room, and we suggest that the advantages to be gained by adopting such a measure would outweigh even such a grave consideration as the loss of accommodation entailed.

The College Authorities, we understand, cannot see their way to allowing the use of a room for cloak-room purposes. If their objections to the scheme are insuperable, could not the locker accommodation in the Surgical and Medical blocks be extended?

The first issue of the Directory of Guy's men (Medical and Dental) produced by Guy's Hospital Gazette Committee is shortly to be published. A copy of the Directory will be sent to every qualified Guy's man, and with it a letter asking for full particulars regarding his career as a Guy's man.

The preparation of this Directory has involved a great deal of work, and while great pains have been taken to avoid inaccuracies, it is possible that some correction may be needed. It is hoped that every Guy's man will furnish the required details, so that the next issue may be complete and up-to-date.

The Directory will be issued annually, and the combined subscription for Directory and Gazette will be 12s. 6d. For this small sum subscribers may obtain a Directory of Guy's men and a fortnightly copy of their Hospital Journal, and so keep in touch with their Alma Mater, and, incidentally, with current advances in medical and surgical science. Suggestions whereby the value or interest of the Directory may be increased will be much appreciated.

We understand that most people make New Year Resolutions. It is, at any rate, a common fiction. If our readers are as human as we suppose them to be, the New Year Resolutions which they have made have now reached their allotted span of days and have all been broken. There is one resolution, however, which we should like everyone to make and keep. Let all at Guy's contribute towards the success of the Gazette. All who have bright ideas, in prose or verse, all who have cases to report, causes to champion, or even grievances to air, should let us know about it. It is only thus that the Gazette can be made really representative of opinion in the Hospital.

It is the proud boast of a London periodical known to many of us that its object is "to amuse, not to instruct." We feel that if we can claim, with justice, to do both, we shall be "going one better." To do this, we need the support of the men at the Hospital.

Readers are reminded that the annual inclusive subscription of 12s. 6d. for the Gazette and Directory is now due, and should be forwarded as soon as possible to the Manager, Gazette Office, Guy's Hospital, London Bridge, S.E. 1.

In accordance with our usual custom we had hoped to publish a drawing or cartoon with this number, to act as frontispiece to the bound volume of the 1922 Gazettes. Unfortunately

our artist has been very busy, and his jealous Muse has, for once, flatly refused to come to his aid. When she relents, we hope still to have our frontispiece, as a supplement to the next issue.

Dr. FAWCETT has kindly lent us a reprint of the obituary notice of the late Sir George Savage, written by Dr. R. Percy Smith, Consulting Physician for Mental Diseases to St. Thomas's, and successor to Sir George Savage at Bethlem Hospital. The memoir was first published in the "Journal of Mental Science," for October, 1921.

Dr. Smith was a personal friend of the distinguished alienist, and had access to records left by Savage himself of his early life. Thus he has been able to write a comprehensive and kindly appreciation, not only of the scientific attainments of a remarkable personality, but also of the more intimate aspects of a many-sided character.

Guy's men have every reason to remember Sir George Savage. He held the post of Lecturer on Insanity for thirty years, and it is not too much to say that his class at Guy's was one of the joys of his life. Some of the details of his earlier career, however, may not be so well known, and Dr. Smith's memoir makes inspiring reading for members of a profession who never cease to be students.

Sir George was a prodigious worker. A twelve-hour day did not always satisfy him, and we read of his taking lodgings in Great Ormond Street, when a student, because this was nearer than Guy's to the Royal College of Surgeons and other Museums. As a reader Savage used to devour the biggest book he could get upon a subject, forget most of it, but remember the essentials. And yet, in spite of all, he found time to be an enthusiastic mountaineer, a fine fencer, a keen botanist, a genial host, and a sympathetic friend.

Of the many little personal sidelights upon his character, we shall always remember the story of Savage ski-ing down a frozen road into a Cumberland village, at the tail of a terrified cow, to the astonishment of his patients.

Such is the charm of his career that we are almost tempted to retail Dr. Smith's obituary notice in full. We appreciate very much this tribute, by a St. Thomas's man, to one of Guy's great men. The friendship between Sir George Savage and Dr. Percy Smith is typical of the bond which has united the two hospitals ever since we were opposite one another in St. Thomas's Street.

WE are glad to see that two of our Governors have been included in the New Year Honours List. Sir R. Nivison, Bart., has been made a Baron, and Sir Rowland Blades, M.P., has received a Baronetcy.

WOODCUTTERS are once again at work in the Park.

In our issue for April 16th, 1921, we earnestly implored the authorities not to denude our shady walks and groves, or convert them into an arid waste. We pointed out that, as it was, there was little enough grass and greenness about the place. We assured them that we thoroughly appreciated a point of view which demanded the removal of a tree here and there, that others might have room to grow. But why, we asked, remove two adjacent trees? We suggested that we should be better served by the sowing of seed on the "lawns," than by the demolition of our venerable planes. In our presentation of the plea, "Woodman, spare that tree!" we believe we incurred the wrath and contempt of not a few amateur gardeners among the High Ones. But still we begged them to spare the trees.

And now they are at it again. True, the tree which has been decapitated stands in the centre of the path. It's removal is a matter of convenience. It is in the way. But we fear that once having started, the sap-lust having been aroused, they will run amuck and massacre all our trees, leaving us nought but a desert.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—It was with great enjoyment that I read Mr. Hopson's address to the Guy's Employees' Association, which reaches a high literary value in that it takes one right out of oneself, and back the thirty-three years into the delightful company of those wonderful old fellows. The great Mr. Wells always seemed to me to be almost a fairy character. While still only Clerk to the Dean he was often—and by all students—taken for that right reverend gentleman himself. That alone was a great *tour de force*. Then again to the superficial he was a hard business man with no side issues—a man of pounds, shillings and pence. But we knew him to be a man of golden heart, full of sympathy and kindliness. I remember his advice given to a poet—Habberton Lulham—"If you take up poetry, do it seriously; sit down *every morning* and write your verses for three hours." Mr. Hopson has finely brought out the humour of Betts and his grumbling slave Hoare; old Betts always struck me as a character out of Rabelais, both in this relationship and otherwise—he would convulse himself with laughter, and told and appreciated a good story.

Of Baker, the physician, and Stockwell, the surgeon, Mr. Hopson has given us a good sketch. I remember a woman at the "Back Gate" asking me if she could see Mr. Stockwell, and added, "Will he be operating?" I can remember Dr. Baker collecting saliva in a beaker, encouraging us by salivating himself, and assisting us by means of a lemon to smell. He was undoubtedly an unrecognised, but great physiologist. To return again to Mr. Stockwell: Mr. Hopson has forgotten to mention a sinister one-eyed man, who acted as assistant or dresser; his chief duties kept him at the tank, but we had reason to believe his knowledge of anatomy was as profound as that of his chief; and he had the same human failing for beer and tobacco, though he used both in the same strict moderation. The Commissionaire was, I think, more of a radical than a socialist. His Atheism was undoubted and sincere. I remember the gloom over us when a young student named James died. I remarked to the Commissionaire, "he will now know whether there is a future life or not." Commissionaire flared out, "He won't know nuffing." When Bradlaugh died I found Commissionaire in tears, sobbing, "Poor old Charlie is dead." He persuaded several of us to accompany him to the "Hall of Science" one Sunday night to hear Mr. Foote lecture on a politico-philosophic subject, which we much enjoyed. Despite his love for tips and his Atheism, Commissionaire was a very upright fellow and thought of things that would astonish you.

Can Guy's produce at the present time such "Employees"? Thirty-three years ago they, the Staff and the Students, seemed to be specially selected. Has the day of "characters" passed and gone?—Yours faithfully,

31st December, 1921. A. P. A.

DEAR SIR,—Now that the first half of the "Rugger" season is over it is interesting to compare records of the leading clubs. It is very gratifying to find Guy's percentage coming out at 85·3, surrendering top place to Cross Keys with 85·7, and being closely followed by Newport with 81, and Blackheath with 80·7. Bart.'s with 40, compare very unfavourably with Guy's. The following is Guy's record to the 31st December, 1921, a splendid one: Played 17, won 14, drawn 1, lost 2. Points for 249, against 82. These figures include the Old Millhillians' match, which I understand will be included in the 1st XV. fixtures. Average points per match for 14·6, against 4·8. I trust that the results of our remaining matches will enable the percentage to continue to creep up. Trusting these figures will be of interest to you,—I am, Yours truly,

100, Elliscombe Road, ROY. C. HOLLOWAY.
Old Charlton, S.E.7.
3rd January, 1922.

DEAR SIR,—May I trespass on your extremely valuable time and call the attention of your exceptionally lofty mind to the consideration of a trifling suggestion.

Would it be possible to publish at the end of each year or half year a small volume consisting of the reprints of the Clinical lectures appearing in your periodical? I realise that it is chiefly a question of demand and believe that a little canvassing by your staff would make clear the amount of support such an innovation would receive.

My own belief is that, as far as contemporary Guy's men are concerned, the above articles and the sporting news are together the chief attraction.

As a comic relief I agree we all enjoy reading "Passim," which, perhaps, would be better headed "Sententious Sayings," or "Ponderous Platitudes."

Their saving grace is their naturalness. Trusting you will forgive this inroad on your valuable time,—I remain, Yours admiringly, "JUDEX."

2nd January, 1922.

In the Theatre.

Old Guy's men often tell me that they are shy of visiting the Hospital and the theatres because they know so few people. As a matter of fact they are always very welcome, and when they wear a mask which conceals their identity they should make themselves known to the surgeon in the theatre.

It has occurred to me that an occasional article on the day's work in the theatre might be of interest to old Guy's men who are unable to re-visit the old place, and I venture to send the following short account of the operations performed during one afternoon in my theatre, with brief comments upon the cases.

Removal of Left Superior Maxilla.

This patient was a very stout old woman, who had suffered for some three months from severe pain in the left side of the face. As in many similar instances, this was thought to be trigeminal neuralgia. There had been some bleeding from the nostril, but no pus. During the last six weeks the left side of the face had rapidly increased in size, the skin of the cheek had become œdematous and the left eye closed. There was no bulging into the palate, but the fold between it and the cheek had become filled out. The eye was not pushed upwards, but there seemed to be solid growth invading the cheek. A diagnosis of carcinoma of the antrum was made, this being more common than sarcoma in elderly patients. The general œdema of the skin over the swelling made it difficult to decide if the growth was removable or not. As, however, the patient suffered such severe pain it was thought to be more humane to remove the superior maxilla.

Operation.—An incision was made through the upper lip, upwards into the left nostril, and then continued in the furrow by the side of the nose and below the left eye. It was carried unusually far back owing to the extension of the growth into the cheek. This flap of skin was turned back and the superior maxilla was removed in the usual way. There was considerable hæmorrhage and some difficulty in removing the extension of the growth backwards.

Intra-tracheal anæsthesia was very valuable in this case, practically abolishing the risk of choking with blood.

Removal of Large Nail from the Foot.

A nail had been embedded in the sole of this child's foot for three months and had caused much pain. An attempt had been made to remove it, elsewhere, but no tourniquet had been used; a search for three-quarters of an hour had proved fruitless and the large longitudinal incision made had suppurated. The radiograms showed the nail to be lying parallel to the second metatarsal in the sole of the foot.

After elevation of the limb a tourniquet was applied and a *transverse* incision made across the line of the foreign body which was soon found and removed, together with its inflamed and blackened sheath of fibrous tissue.

It seems foolish to attempt to remove a foreign body from a limb without the aid of a tourniquet, and also to cut parallel to the foreign body instead of across its line. It is always wise to remove its sheath for the latter may contain bacteria and possibly even the bacillus of tetanus.

Removal of Internal Semi-Lunar Cartilage.

This patient, a young man, gave a typical history of recurrent displacement of the internal semi-lunar cartilage, with locking of the knee-joint.

The limb having been raised and a flat tourniquet applied around the middle of the thigh, a vertical incision, three inches long, was made over the inner side of the knee, one and a half inches internal to the patella ligament. The joint was opened above the cartilage, the posterior two-thirds of which was seen to be displaced inwards from its natural position. There was recent and organising clot adherent to the displaced part of the cartilage. The cartilage was removed without difficulty and no loose body could be seen in the inter-condyloid notch.

The incision in the capsule was not sutured, but the skin was united with fine linen thread, and a massive dressing firmly bandaged around the knee before the tourniquet was removed.

The use of a tourniquet is invaluable for the removal of loose cartilage from the knee, as in all other operations upon the limbs, for the bloodless field which it ensures saves time, provides a good view and allows accurate work to be carried out without delay, or sponging, or catching vessels with forceps. There is no need to remove the tourniquet for catching blood vessels before the wound is closed, on the contrary, it is better to keep the tourniquet on until the bandage has been applied. In this way bleeding is entirely prevented and very little effusion takes place in the knee, so that the patient can get up and walk about a few days after the operation, and thus make a more perfect as well as a quicker recovery.

Nephrectomy.

(For Acute Tuberculosis of the Left Kidney.)

Patient was a girl aged 13. She had had remittent fever for six months; in the evening temperature was 101° or 102°, in the morning 97. She had wasted a great deal and her skin was dry and hot. The abdomen had been enlarged and a provisional diagnosis of tuberculous peritonitis was made at the Cottage Hospital where she had been carefully watched for some time. The urine had always been normal and there was no diarrhœa.

When she was admitted into Guy's there was definite tenderness over the pelvic and right iliac regions, and it was thought that subacute appendicitis was a likely cause of the symptoms. There was frequency of micturition, however, and on one occasion blood and albumen were found in the urine and bacteriological examination revealed tubercle bacilli. X-ray examination did not show any abnormality in the urinary organs. Cystoscopy did not help much owing to cystitis and difficulty of filling and retaining liquid in the bladder, also owing to bleeding from the bladder mucosa. No indigo carmine appeared in the urine at the end of the first hour. The right kidney appeared large and low on palpation; the left could not be felt. There had been no tenderness over either.

It was decided to explore both kidneys in the hope that the disease might be confined to one.

Operation (28th November, 1921).—The patient was placed in the prone position, over a rubber pillow. The right kidney was explored through a vertical incision in the loin and was found to be normal, but enlarged. The wound was closed and the left kidney was explored in a similar manner and found to be nearly three times its normal size, and adherent, but it was fairly easily delivered and removed, its pedicle being tied with strong cat-gut. The ureter was not thickened.

The operation lasted twenty minutes only, so that the patient was not appreciably shocked.

It appeared that, without an operation, the disease would inevitably be fatal, and as there was no sign of general tuberculosis it was thought worth while exploring the two kidneys. If one was normal and the other diseased, nephrectomy could hopefully be performed. This was the only way to make an accurate diagnosis, cystoscopy having in this instance failed.

With the patient lying on her face it was quite easy to examine the two kidneys without delay, and the vertical incision gave plenty of room for nephrectomy. It is more than probable that the cystitis will heal, as is usual, once the diseased kidney has been removed.

It is curious that the urine had been found to be normal on repeated examinations, and it is, therefore, probable that the left ureter had been blocked. The inflammation around the left kidney had caused the abdominal distension, a symptom not uncommon with inflammation around the kidney, and this had led to the diagnosis of tuberculous peritonitis, as in several previous instances in my experience.

On opening the kidney after removal, an abscess the size of a walnut was found in the cortex, and tuberculous masses and nodules were found throughout the kidney.

R. P. R.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

The Niggers.

As Christmas fell on a Sunday, it was on Boxing Day that the Hospital once more rang with the noise and laughter of a strange and weird troupe, composed of diverse types and original characters. We recognised amongst others two Apaches (one American and the other Parisian), an Irish gentleman of obvious means, and two ladies of uncertain age though very juvenile behaviour, accompanied, strange to say, on the one hand by a most ascetic parson, and on the other by—Mephistopheles! Mutt and Jeff, a bookies' tout, a coster, and Landru

helped to swell the ranks of this strangely assorted company, whilst pierrots and other odd beings abounded.

These, in truth, were the Niggers, who, each year, sally forth from the College Quadrangle, and after being photographed, proceed to the wards heralded by a chorus which announces to the bewildered bystander that the Niggers are with us once more.

Starting at 12 in the Eye Ward, performances were given in every ward in the Hospital, until finally Astley Cooper was reached, and what must have been an exhausting, if hilarious, day for the performers came to a close.

The songs this year were good, especially if one considers the inept material which the modern music-hall makes available for this sort of show.

The "hits" were a duet entitled "Linger a little longer with me," and also the patter which Massa Johnson (Mr. Doherty) and Mr. O'Meara, carried on at intervals during the afternoon, indeed the spontaneous humour of the latter contributed largely towards the success of the day.

In Out-Patients, as usual, enthusiasm reached its height, and amid song and pandemonium it was shown that the memory of Landon still lives in the mind of the Borough child.

There is little to criticise: the costumes were if anything better than in previous years; on the other hand the Chorus sang with less spirit than is the rule, so that the choruses sometimes flagged in consequence.

In addition the "gags" were of an inferior order. They consisted mainly of the "Do you know Jerry —Jerry who?" type—that atrophic form of humour which the ancients once designated as the lowest form of wit.

Ward Concerts.

ADDISON.

The Addison Ward Concert, amidst real Yuletide decorations, went off with a swing from the very commencement. The general effect gave everybody the right spirit to enjoy a pleasant afternoon.

The first artiste, a comedian, kept the younger and even the older people in shrieks of laughter. He was followed by songs and recitations from various kind friends until tea, after which more songs, recitations, and humorous dialogues followed each other in quick succession. Messrs. Richards and Wallace brought forth loud guffaws in their skits on the Staff. The turn itself was great. Towards the close of the concert three members of the D'Oyle Carte Company lifted the audience completely out of itself and without a doubt were the chief attraction. Old people joined with the young in making ragtime.

The National Anthem brought a finish to a very bright and cheerful afternoon.

Sister Addison, after being cheered to the roof, was called upon to make a closing address, but declined with thanks. Cheers were given to the friends who so kindly come to liven the spirits of the patients and their relations.

Our unlimited thanks are due to Misses Wentworth, Jofferson and Russell, who gave very bright and humorous recitations, intermingled with dialogues and stories. Messrs. Bradfield and Fawkes achieved great

honours with their songs, especially the former, who delighted the audience with his playing at the piano. Dr. Turton, as of old, charmed everybody with his rendering of various Folk songs.

Great credit is due to Sister for the management of the concert, and the beautiful tea which was partaken of by everybody.

Messrs. Elkington and Turner did the stage managing.

ASTLEY COOPER AND CORNELIUS.

Astley Cooper Ward was literally packed on Wednesday afternoon, December 28th, when the ini-

mitable "Cosmopolitan Five" opened the Astley Cooper—Cornelius Concert with their delightful syncopated tunes. A sumptuous tea had been prepared by Sister Astley Cooper and Sister Cornelius and was served while the band played.

The concert in its entirety was provided by artists from those two great schools of talent, the Nurses' Home and the College. Charming songs were rendered magnificently by Nurses Keane, Young and Dalbiac, and it was indeed unfortunate that time allowed but one encore for each singer. Messrs. Lloyd, Lansdowne and Burvill-Holmes gave of their inborn humour and each was in turn called back, as was Mr. Canning after his catchy songs; a clever local topical duet by Messrs. Richards and Wallace was thoroughly enjoyed by all "in the know." The audience was captivated by Mr. Watson's gifts of tune and expression in his songs; Mr. Crisp was equally successful, and Messrs. Lansdowne and Woodruffe in their duets brought the house down.

One heard remarks from all directions on the skill and sympathy with which Mr. Richardson is endowed as an accompanist at the piano.

Mr. Doherty passed a very hearty vote of thanks to the artists and to Sisters for their untiring efforts and a wonderfully successful concert closed with three rousing cheers for Sister Cornelius and Sister Astley Cooper.

ESTHER,

Esther Ward was entertained on Tuesday by an excellent Concert Party organised by Mrs. Odette Wellmon, whose sister is at present a patient. About 200 people were present.

An excellent programme was provided. The concert opened with Mr. H. M. Wellmon at the piano with his own version of "Il Trovatore," followed by Mr. Lew Geary in an Italian Monologue. Then Mrs. Wellmon gave us a treat with an imitation of Alice Delysia singing "Ninon." Two songs by Mr. Stanley Lipsey brought us to the chief item in the programme —Messrs. Carlish and Wellmon in their original scene "The Haunted Castle." Imagination was necessary to turn the stage provided into the interior of a Haunted Castle, but, that accomplished, ghosts and goblins abounded, only to be banished by rollicking ragtime.

Here the artists were given a rest, and they and the audience partook of an excellent tea provided by Sister Esther.

The second part of the programme was as good as the first. Space will not permit a detailed account, but we may mention that Johnny Dunbar with the drums, and Lewin and Mac, the black-faced comedians, gave us of their best, and an excellent concert was brought to an end by Messrs. Carlish and Wellmon and the rest of the party with a selection of popular songs. Our thanks are due to Mrs. Wellmon for her great kindness in providing an excellent afternoon's entertainment, and our congratulations to Sister and the Nurses on the splendid results attending their efforts, which went so far in rendering the afternoon so enjoyable.

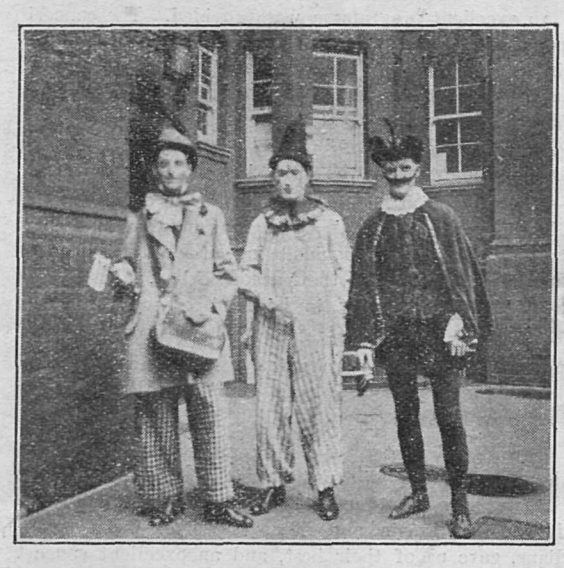
PATIENCE AND SAMARITAN.

This Concert was held on December 27th, at 3.0 p.m. The Misses Young opened the programme with a very pretty duet and were loudly encored. Nurse Young also sang alone, proving we had not

got to go outside the Hospital for talent. Other items on the programme were Mr. Canning in "Currant Buns," which caused great laughter. He also sang the "Kashmir Song." Messrs. Wallace and Richards gave a short dialogue on "Hospital routine in general." Mr. E. T. Lloyd sang two very merry songs. Mr. Lansdown caused much amusement, especially in "Braces," and "Let's have a jolly good cry." Mr. Silver kindly sang two excellent songs.

Owing to illness, two members of the Cosmopolitan Five were unable to appear, but the remaining members of the orchestra kindly came to brighten up the tea interval, playing many well-known tunes. They also accompanied Mr. Watson in his song "Coal Black Mammy." Later Mr. Watson sang "And her mother came too." Mr. Wells gave a Pianoforte Selection.

The concert ended up with a vote of thanks to Sister for her energy in making the Xmastide a happy one for the children.



EVELYN.

A very enjoyable Concert was held in Evelyn Ward on Thursday, December 29th.

The Sister of an old Guy's men—Miss Remington—who has helped us for several years at Christmas time, again brought a Concert Party whose diversity of talent delighted us, although one large share of applause went to Miss Remington for her rendering of "Songs my Mother Sang to Me." Mr. Lansdowne amused the audience with his song "Our's is a Nice House Our's is," and Father Christmas also honored us with his songs.

The concert closed with "Sing a Merry Madrigal," from the Mikado. All the patients enjoyed themselves very much.

EYES.

This Concert was held on Thursday, December 29th, and despite the fact that five other concerts were in progress at the same time, the available accommodation did not prove sufficient.

The Ward was magnificently decorated by Sister and the Nurses to represent "Sport," and it seemed that every form of it had been faithfully reproduced, though, as ever at Guy's, Rugger was the main theme.

Mr. H. Richards had got together an excellent programme and is to be heartily congratulated upon the success of the concert. The now famous Guy's Jazz Band, the Cosmopolitan Five, started the proceedings with a swing, and were very much appreciated. Miss Lucy Nuttall next sang some songs, followed by Miss Mary Oswald, who rendered two admirable violin solos, and Miss Irene Ward's recitations were excellently delivered. Mr. Clay Thomas was in fine form and his songs were heartily encored. Mr. Smith amused everyone and his laugh proved infectious. He cleverly produced music from an instrument made out of an old cigar box and a piece of wire, and finally showed his skill as a ventriloquist.

In the interval a sumptuous tea was provided by Sister and the Nurses.

Upon resuming Miss Olive Sturgess' singing delighted everyone and her songs revealed her beautiful voice to perfection. But perhaps the most popular turn of all was that of Messrs. Richards and Wallace, the words of whose songs, written by themselves, were of great topical interest. We believe they had rehearsed hard and long for this concert and they richly deserved the vociferous applause that their efforts called forth. Mr. Wallace, disguised as a Sister, successfully deceived most people—until they heard his voice! Mr. Hart ably accompanied them at the piano.

Miss Renée Rice, dressed as "The Kid," sang two songs. Mr. Crisp then sang his two Nigger Songs, "Here you are then" and "Whiskers" in his own inimitable style. (We wonder how many miles he has walked while singing his songs this Christmas!) A most enjoyable entertainment was brought to a close by the singing of the National Anthem.

LANDON OUT-PATIENT TEA.

It is common knowledge that Sister O.-P. is being translated to a higher sphere, but this translation was delayed till after the Landon Tea. The success of that function justified the decision of the powers that be.

The originator of the Christmas Tea Party for Outpatient Children is surely one of the real benefactors of the Borough and of the Hospital, at least as far as the O.-P. Department is concerned. Where

THE NIGGER TROUPE.—CHRISTMAS, 1921.

would be the fun of Xmas were it not for the Tea Party, involving as it does the pleasure of preparation and the greater pleasure of handing out tea and buns to 700 children; to hand a piled up plate of buns along one of the tables is to illustrate the saying that "the quickness of the hand deceives the eye"—the plate empties in the twinkling!

The party counted as its greatest asset the usual visit of the Niggers, and the songs were all sung by the audience so loudly as to drown the band—also according to custom.

A new feature of the entertainment was the presence of Father Christmas to hand out gifts; the onerous duties were carried out by Messrs. Kendall and Woodroffe; by a cunning device the former was saved from destruction by the mob. Why are girls so much less easy to manage than boys?

LAZARUS AND MARTHA.

The Martha and Lazarus Concert was an undoubted success from the very beginning, and was thoroughly enjoyed by a very large audience. The programme opened by an enlivening tune by the inimitable "Cosmopolitan Five," which was followed by songs by Mr. Wilson, Mr. Booth, Mr. Lloyd and Mr. Burville-Holmes, whose song "The Eggs," was particularly enjoyed by the younger members of the audience! There were then some excellent recitations and sketches by the Misses Hobil and Beaven, and Messrs. Booth, Woodruff and Nunn.

After the first half of the programme was over everyone had tea, which was a lavish meal with an abundance of all good things to eat and much enjoyed by everyone, this being largely owing to the excellent organisation of the respective Sisters of the Wards.

Tea over the concert continued by a very amusing and clever sketch entitled, "Behind the Bathroom Door," in which the Misses Beaven, Hobil, Barber, and Messrs. Booth, Wilmott, Newtown and Nunn were the performers. This was followed by some delightful and beautifully rendered songs by Miss Dunmore, Mr. Eastland, Mr. Galligan and Mr. Lansdowne, whose two songs "The Roast Beef of England" and "Our's Is a Nice House Our's Is," will be remembered by the younger members of the audience who could not resist joining in the chorus for a long while to come.

Mr. Bramwell, with his delightfully humorous and beautifully rendered recitations was an especial source of delight to everyone and to do his performances justice would take up a page to himself, but neither time nor space permitting of this we must confine ourselves to thanking him most heartily for the great pleasure he gave. We hope we may have further opportunities in future Christmas' of hearing him again.

Miss Doreen Warwick did two delightful dances, and it is to Mrs. Warwick we owe thanks for the accompanying of most of the songs.

We could go on writing pages on the delights of this concert and the enjoyment it gave to so many people young and old as there was something to suit everyone's taste, but this is not possible, so we must be content to thank all the artistes most gratefully for the pleasure they gave. We hope we shall have other opportunities of seeing and hearing them again in the future.

LUKE AND CHARITY.

On Friday, December 30th, the Christmas festivities of the Hospital were brought to a close by a most excellent concert arranged by Charity and Luke Both wards were beautifully decorated; Charity was hung with festoons of anemonies of every colour and Luke was turned into an orange grove. Owing to

the larger size of Charity the concert was held in that ward.

The success of the concert was shown by the size of the audience; not only were all the seats filled, the aisles and doorways were crowded with people standing. Mr. Corelli Windeatt's orchestra played during tea and Miss Tommy Graham sang the first song. "Alice Blue Gown" was sung by Miss Hazel. Miss Helen Mar then told us several amusing stories about blood oranges and other interesting things, and Mr. Schrader followed her with a song. Again the orchestra played and so inspiring was the rhythm that many of us, unable to resist the temptation, found partners and tripped a measure in Luke.

Miss Olive Sturgess then gave a fine rendering of "The Wandering One," and Miss Helen Mar

treated us to more stories. Madame Adele Hull sang a couple of songs, one of which, "Love's Gift," was composed by Mr. Corelli Windeatt's son at the age of fourteen. Mr. Gus Garrick followed with "Our's is a nice 'ouse our's is," and not only succeeded in persuading the ladies to sing the chorus alone, but also got the children to sing it standing on the platform in their sailor suits and white bows. As an encore he sang "Physical Jerks," which was remarkable for the simplicity of its chorus.

Mr. Leslie Harris gave us some amusing piano sketches including "The wooing of Phyllis," and "A rehearsal of the Village Choral Society." Miss Hazel then appeared again and sang "My Coal Black Mammy," and once more the lungs of the audience had full scope for expansion. This delightful programme was then brought to an end with another song by Miss Tommy Graham, and a pot-pourri of National Airs by the orchestra.

We cannot end this account without expressing our heartiest thanks to all the artistes who so kindly came and gave us of their best. We congratulate them on their success in bringing so much pleasure to their audience. We offer our thanks to the Sisters and Nurses of Charity and Luke for all the trouble they took in arranging the wards and in supplying so excellent a tea, to Mr. Campion Smith for his skilful drawing up of the programme, and finally to Sir Alfred Fripp for the part he played in bringing together so many brilliant artistes into so small a space.

MARY.

Mary Concert was held on Tuesday, December 27th. Unfortunately no notes of the individual items were made at the time, but one is left with the general impression of a very pleasant afternoon.

The programme, arranged by Mr. Herbert Collins, was varied, and contributed to by both amateurs and professionals. The comments of the patients (who form a most critical audience) left no doubt that the main object of the performance—that of entertaining and cheering the sick—had been achieved.

Sister Mary, whose hospital career we regret to state was brought to an end by Xmas week, acted as hostess with her usual charm and popularity. We wish her every happiness in her married life.

NAAMAN AND DORCAS.

On Thursday, December 29th, a most enjoyable Concert was held in Naaman Ward. Owing to the kindness of Mr. and Mrs. Rowlands, we were able to enjoy the services of four excellent artistes, namely, Miss Amy Brooke and Miss Violet Clark, and Messrs. Gorton Young and Arthur Melville, with Mr. Harry Stubbs at the piano. In addition we were fortunate in having the "Cosmopolitan Five" to start and finish the concert with a selection of the latest Jazz music, which all thoroughly enjoyed. Drs. Watson, Lansdown, and Burville-Holmes also kindly helped, and sang with great success their songs, to the obvious enjoyment of the kiddies, who always love to see the "doctors" in a different rôle.

This year the ward was most originally decorated—a series of ships of varying colours suspended from the ceiling and lighted inside, while round the sides were stationed lighthouses illuminated from inside, all giving a most cheery aspect to the ward. Sisters Naaman and Dorcas, the Nurses and Mr. Rowlands' Dressers and Ward-clerks are all to be congratulated upon their untiring efforts to make Christmas for the patients as happy a time as possible.

At the conclusion of the entertainment a vote of thanks was passed ro the artistes and to Mr. and Mrs. Rowlands; and the enthusiasm with which "Three cheers" were given for them both by the patients and visitors was sufficient to show the appreciation and thanks that all felt for their great kindness. We all hope that next Christmas we may having the pleasure of seeing and listening to them again, so that Naaman and Dorcas concert may once more have the distinction of being voted "the best of the lot."

QUEEN AND VICTORIA.

That the large crowd which gathered in Queen Ward for the Concert were more than satisfied with the very excellent programme, was shown by the very appreciative way all attended to each item and the vociferous applause which was accorded each artist.

Sister and staff had arranged the stage and decorations in a simple yet effective manner, which showed good taste. The artistes were all extremely good and most of the turns were of a very high order. The D'Oyle Carte Opera Vocalists were greatly appreciated and commanded the rapt attention of all present. Messrs. Marais and Maree both gave excellent turns, and Miss Pond got a great reception. Local talent, viz., Messrs. Watson, Holmes and Carling, were certainly one of the draws of the evening. The last item was a duet by Messrs. Lansdowne and Woodruff in their irresistible style which made the ward resound to the thunderous applause. The programme was concluded by "God Save the King," and Mr. Lansdowne called for three heartily deserved cheers for Sister Queen and Mr. O'Meara.

The latter is to be congratulated on arranging such an excellent programme.

During the interval Sister, assisted by the Nurses, gave a spread which would have satisfied the most critical of epicures.

STEPHEN XMAS TREE.

Father Xmas paid a visit to Stephen on Wednesday afternoon, arriving on his fiery charger, and was greeted with shrieks of delight from the fifty children assembled. After a brief apology for being a few days late, and an explanation that there were so many children to visit nowadays, he proceeded to produce wonderful presents from his store. No one was surprised that he knew every child's name—of course, Father Xmas always does—and when at Sister's special request he paid a visit to Esther to two patients who were too ill to come to the Xmas Tree themselves, everyone waited in breathless silence for his return. On his way back he found a present at the bottom of his sack which he had overlooked before, and thus saved one small imp many tears for what would have been an unforgivable oversight.

We were sorry he could not stay longer and tell us of his travels, but he still had many places to visit and much good work to perform. We must wait patiently until next year, when we hope he will find time to be with us once more.

STEPHEN CONCERT.

On Thursday, December 29th, Messrs. Wellmon and Carlish entertained Stephen Ward with a Concert. This was a wholly unexpected pleasure, for no official concert had been arranged. However, the artists, who had been kind enough to entertain in Esther earlier in the week, expressed their willingness to do the same for Stephen Ward and naturally the offer was gratefully accepted.

In Stephen, as in Esther, an excellent programme of songs, music and recitation was provided, which contributed greatly to the happiness and amusement of patients and guests. At the close of the concert, which lasted nearly three hours, hearty cheers were given for Mrs. Wellmon, who had arranged it in the first place, and for her fellow artistes.

JOB.

This Concert was held in Job Ward on Wednesday, December 28th, and was voted by all present to be a great success. Owing to the fact that the performance was intended chiefly to entertain the patients, it was not advertised very strenuously. Nevertheless, a fair number of other people, not patients, were present.

It was primarily due to Mr. Curling, who was a patient in Job in 1920, that Miss Grindley was

able to secure for us the services of Miss Nellie Beare's Concert Party, who delighted the audience with items from their répertoire.

The concert began with a performance by the "Cosmopolitan Five"—the Guy's Jazz Band. Next, Mr. Harry Hodson, after a graceful compliment to the preceding performers, began the Concert Party's programme with two songs which were much appreciated. After this, Miss Nellie Beare sang two charming songs—"Love's a Merchant" and "Songs my Mother Sang."

Miss Marcia Bourn then entertained us with songs at the piano, and assured us that "She didn't want to give herself away," and Mr. Will Thorne kept the whole audience in fits of laughter with his songs and patter, his views on profiteers being especially appreciated.

Miss Beare and Mr. Hodson enthralled us with two duets. In one, entitled "You need Sympathy,"

Mr. Hodson was *most* sympathetic, to the great delight of the kiddies in the front row.

Hospital talent now came to the fore, and Mr. E. T. Lloyd and Nurse Young contributed very popular items.

Miss Beare's Party then gave some more of their songs before leaving and concluded with a number of choruses in which the audience joined. Before their departure Mr. Lloyd expressed our thanks to them for so kindly coming to entertain us, and three hearty cheers were given.

Finally, Mr. Burville-Holmes and Mr. Crisp sang some of their "Nigger" songs, and the concert was concluded with three hearty cheers for Sister Job.

LYDIA XMAS TREE.

As has been the custom in past years, the Children's Party took place again in Lydia. The kiddies had a delightful afternoon and went away loaded with tea and presents.

The entertainment commenced with a real old-time Punch and Judy show. The children were enraptured and applauded loudly as Mr. Punch killed off in succession the policeman, the bailiff, and the clown. This was followed by a tea in Job, where about a hundred children did ample justice to the more serious part of the show.

During a short interval there was some music by the Cosmopolitan Five, which embodies purely local talent.

With expectant faces the children awaited the advent of Father Christmas. The big tree was heavily weighted with presents, and the dramatic entrance of Father Christmas through the window elicited a fine burst of cheering. Mr. Lloyd filled his part extremely well, and it was charming to see how many of the children were frankly puzzled as they went up to receive their presents. Here was a perfect Babel of voices as they discussed their toys, but there was a sudden hush as Mr. Wells' name was called out, followed by much laughter when he advanced to receive his rattle. Mr. Joffe received a pop-gun, but he could only be coaxed from his retirement with difficulty.

When all the presents were distributed Mr. Lloyd made a short speech and called for cheers for Mrs. Steward for bringing the Punch and Judy show, and for Sister Lydia and Sister Job for the unsparing way in which they worked to make the party a success. Three very hearty cheers were given, followed by three more for Father Christmas himself. The whole entertainment was extremely successful and well rewarded the untiring efforts of its promoters.

BRIGHT WARD.

The Concert in Bright Ward was held on Tuesday afternoon. Influenza and, presumably, excess of Christmas had taken their deadly toll from among the prospective performers and more especially among the pianists, so that it was with heartfelt relief that one saw Mr. Richardson mount the platform for the opening piano solo.

Some delightful songs were given by Miss Lindsey and Miss Edwards, and comic relief was supplied by Mr. Karminski, who with his songs at the piano carried all before him. Also one would have liked to have heard much more of Miss Harverson and his 'cello.

To show what the Hospital could do Mr. Watson—in spite of his labours in the Niggers on the previous day—gave us a pathetic insight into his domestic affairs, and drew the sympathy of all present, while at the piano Mr. Richardson treated the most difficult accompaniments with splendid contempt.

Altogether it was a very enjoyable afternoon, and it would be difficult to say which of the two—the truly noble tea which sister Bright and her indefatigable Nurses provided, or the concert—was the more appreciated.

Change of Address.

G. E. Genge-Andrews, O.B.E., M.D.Lond., 21, Craven Road, Hyde Park, W.2. ('Phone, Paddington 4379.)

Papers by Guy's Men.

Maurice Coburn, M.B., B.S. Insomnia following Encephalitis Lethargica.—*Jour. Neur. and Psychopathology,* Vol. ii., 1921.

Alan H. Todd, M.S., B.Sc., F.R.C.S. Common Disabilities of the Feet in Children.—*Clinical Journ.*, L., 1921, p. 778.

Sir W. Arbuthnot Lane, M.S., F.R.C.S. The Importance of Thoracic Respiration.—*Lancet*, 1921, ii., p. 1317.

R. P. Rowlands, M.S., F.R.C.S. Some Fractures.—*Clinical Journal,* L. 1921, p. 785.

——. Case of Partial Pyloric Stenosis (Hypertrophic): Finney's Operation.—Proc. Roy. Soc. Med., xv., 1922, Clinical Section, p. 5.

Pass List.

Society of Apothecaries of London.

December, 1921.

Medicine.—M. T. A. Elna Keeb.
Forensic Medicine.—H. Aminn.

Song from the Unpublished Opera, "Patients."

If you want to shine in practice, the indubitable fact is
You must come with something new;
Trace each chronic rheumatism to some psychic cataclysm
At the age of one or two.
If you scorn all drugs and doses and unearth suppressed neuroses,
Men will think you kind and wise,
And you'll soon be making money in a land of milk and honey
When you psycho-analyse.

And everyone will say,
As your fees they gladly pay,
"If old Mrs. Brown keeps telling him things
She certainly would not tell me,
What a psycho-analytically gifted man
This gifted man must be."

Then a therapy hormonic must replace the well-worn tonic,
Which has long since had its day;
For with glandular injections you'll establish new connections
And you'll make the practice pay.
You will treat the old and bibulous with extract infundibulous;
You'll cure the halt and lame,
And make them skip like flappers, if your bottles and their wrappers
Bear an autocoidal name.

And everyone will say,
As you walk your ductless way,
"If this young man takes monkeys' insides
And puts them once a week in me,
Why what a physiologically wise young man
This wise young man must be."

The routine examination by inspection and palpation
You must spurn as out of date;
Auscultation and percussion must give way to methods Russian
When you investigate.
You must peer down every speculum, and, e'er they try to check you lum-
Bar puncture them, and frown
On a Wasserman or Widal done without "my special needle
Made for me by Messrs. Down."

And everyone will say,
As you walk your learned way,
"If this young man discusses my pains
In terms that are Dutch to me,
Why what a very educated type of mind
His type of mind must be."

Guy's Hospital.

In accordance with annual custom the House-Committee publishes for the information of the Medical, Surgical, and Nursing Staff the following Tables showing the total number of Patients sent during the past year to Convalescent Homes and Sanatoria.

Wards.	Number of Patients. 1920.	1921.
Astley Cooper	13	9
Cornelius	15	17
Lazarus	40	26
Job	22	30
Naaman	32	24
Luke	54	51
Patience and Samaritan	11	26
Evelyn	16	4
Charity	48	63
Dorcas	69	21
Lydia	31	48
Martha	46	35
Eye Wards	9	16
Addison	29	31
Mary	10	29
Stephen	32	37
Esther	11	20
Queen Victoria	20	17
Clinical	2	—
Out-Patient Department	96	*14
	606	518

The subjoined list gives the distribution of the Patients amongst the various Homes:—

Ascot Priory (Women and Children)		58
Merchant Taylors' Home (Bognor) (Men)		28
Metropolitan Convalescent Institution:—		
Bexhill (Women)	87	
Bexhill (Little Common) (Men)	39	
Broadstairs (Children)	90	
Walton-on-Thames (Men & Women)	35	
		251
†Parkwood, Swanley		40
Rustington Convalescent Home		46
Schiff Home of Recovery		79
		502

*In addition to the above, sums amounting to £98 8s. 1d. have been contributed by the Samaritan Fund towards 65 cases sent away by the Invalid Children's Aid Association and the Charity Organisation Society for long periods of convalescence.

†At the end of October, 1921, the Hospital Convalescent Home, Parkwood, Swanley, which has not received convalescents since the middle of 1916, re-opened for the reception of women and children, and 40 patients have been sent there up to December, 1921.

Parkwood has kindly concented to receive cases from Guy's which need only prolonged rest in bed, with ordinary nursing, and but little treatment—such as cases of Heart Disease and Rheumatism—thereby setting beds at the Hospital free for more acute cases.

SANATORIA.

(Beds allocated free of charge to the Hospital by the King's Fund):—

Benenden	3
Devon and Cornwall Sanatorium	11
Kelling Sanatorium, Holt, Norfolk	1
Holt Sanatorium (Children)	1
	518

Reviews.

Cataract and its Treatment. By Colonel H. Kirkpatrick. (Oxford Medical Publications.) Price 12s. 6d.

Colonel Kirkpatrick's book on Cataract and its Treatment is an extended account of much of our present knowledge on this subject, and is a very valuable addition to the books which a young ophthalmic surgeon should possess.

The method of extracting a lens in its capsule, is of course referred to, but curiously very little is made of the most important objection to its employment, viz., the necessity of making an unusually large incision. When we remember the average size of the crystalline lens in its capsule, and the average diameter of the Cornea, we realise that the incision must be invariably a little short of half the circumference of the Cornea, if the lens is to be delivered in toto. The difficulty of making such an incision, and when made the disadvantages of it are so great, that most Metropolitan surgeons feel that the older method which has yielded such excellent results in their hands, is to be preferred.

However it is right that the latest methods should be tried and the newest ideas put into practice. One would, however, for the sake of historical accuracy, point out that many so-called new methods were tried and practised by a generation of Ophthalmic Surgeons now passed away, but were not generally advertised by them, so as to become widely known. Smith's Lid Control is certainly one of these. This was used in certain cases of difficulty, twenty years ago at Guy's and no doubt elsewhere.

The book is well printed, most of the illustrations are useful, but some, and often the most elaborate, are of doubtful utility.

The book may certainly be recommended to every ophthalmic student.

Pathology of the Nervous System. By E. Farquhar Buzzard, M.A., M.D., F.R.C.P., and J. Godwin Greenfield, B.Sc., M.D., M.R.C.P. (Messrs. Constable and Company, Ltd.) Price 30s.

The distressing tendency which has long existed, to regard the nervous system as an isolated system has led to its partial or complete exclusion from the text books of general pathology. The need for a work such as this has consequently long been felt by the student of medicine, and the authors are to be congratulated on the masterly manner in which they have supplied this want.

In the first section the general pathological processes of the nervous system are discussed, and here one finds perhaps the most lucid account of neurological reactions to pathological processes which exists in our literature. The mode of formation of the cerebro-spinal fluid, its variations in disease, and the technique involved in its investigation are well described.

Whereas the book consists mainly of descriptions of pathological findings in disease, yet some theories are advanced which are also worthy of consideration. For instance, the authors suggest that the pronounced lethargy in some cases of encephalitis lethargica is due to intermittent blocking of the aqueduct of Sylvius, but bring forward no evidence in support of this.

Again, it is pointed out that the polyneuritis of beri-beri does not occur on a water diet, but developes on carbohydrate feeding when water-soluble B is absent. The inference is that this vitamine owes its beneficial action to neutralisation of some poison resulting from carbohydrate metabolism.

The sections dealing with syphilis and tumours of the central nervous system are above criticism, and it is satisfactory to note that the term penthelioma is mentioned only to be dismissed as unscientific and inaccurate.

Brilliant descriptions of the pathology of subacute combined degeneration and paralysis agitans are included, the recent work of Hunt on the pallidal system being given due prominence.

The book is profusely illustrated, the majority of the reproductions being excellent. One other praiseworthy feature is the attempted correlation of anatomical findings with the observed clinical phenomena of each disease considered.

In short, the work is admirably adapted to supplement existing text-books of systemic pathology, and will be of the greatest value, not only to the neurologist, but also to every student of general medicine.

Symptomatology, Psychognosis and Diagnosis of Psychopathic Diseases. By Boris Sidis, A.M., Ph.D., M.D. (Messrs. E. and S. Livingstone.) Price 21s.

It is fortunately rare to read a work in which the author displays the degree of bias presented in the Introduction of this book. The unhappy victims of the tirade are Freud and his disciples whose

tenets are described as "Schopenhauerian metaphysics gone mad," and again as "perverted 'madical' metaphysics." Further childish references to psycho-analysts as "medical dignitaries taking a regular bath in sexual filth," or of presenting "puerile compositions, each a mile long, going into detailed description of sexual experiences," demonstrate such a lack of self-restraint and literary attainment that the reader is apt to be repelled from the book before even reaching its subject-matter.

Further perusal is, however, justified, for Dr. Sidis later expounds his well-known and interesting views on the hypnoidal state which he believes to exist on the borderland of waking, sleep, and hypnosis, and to be a vestige of a primitive rest state; one feels, nevertheless, that it is a quibble of terms to affirm that it cannot be identified with light hypnosis.

Psychopathic symptoms he believes to have no meaning in the present, but to be relics from a previous epoch of the life of the patient, who will readily attach meanings to them if given the opportunity. It is difficult to comprehend how such views can still be adhered to in the light of psycho-analytical investigations which have conclusively shown that very definite evidence of such meanings are forthcoming, even when all possibility of suggestion by the operator has been excluded.

The sections on dreams are scarcely illuminating, except in providing an insight into the author's mental attitude towards the one school which has really inestimably benefited mankind by its researches into these phenomena. Psycho-analysis of dreams, he states, displays not only arrogance of the ignorant parvenu in psychology, but also manifests a total incapacity of comprehension of psychological problems. Could the author but bring himself to examine results rather than indulge in theoretical considerations, he would, perhaps, be more ready to extend at least that modicum of indulgence to others which is due to them, even though their views differ from his own.

Polycythæmia, Erythrocytosis and Erythræmia (Vaquez-Osler Disease.) By F. Parkes Weber, M.A., M.D., F.R.C.P. (Messrs. H. K. Lewis & Co., Ltd.) Price 21s. net.

The author has performed a no mean feat in presenting this intelligible account of the hitherto ill-defined group of cases in which increase of erythrocytes formed the dominant element. Although attention is chiefly concentrated on cases of true erythræmia, yet a section of the work is devoted to a description of the various conditions in which a relative or absolute polycythæmia is present.

Polycythæmia rubra is here divided into relative and absolute forms, the former relating to concentration of blood through general fluid loss, e.g., diarrhœa, and being, therefore, usually of short duration, the latter referring to cases in which the total number of circulating red blood corpuscles is definitely increased as is also the total blood volume.

Of the absolute polycythæmias, two classes can again be distinguished, viz., cases in which the corpuscular increase represents a vital reaction to known stimuli, e.g., congenital pulmonary stenosis, and is analogous to a leucocytosis, and cases where the increase appears to depend on a primary disorder of the bone marrow and is analogous to leukæmia. The former is named erythrocytosis; the latter erythræmia.

Having thus defined his main subject, the author brings forward a wealth of interesting detail relating to the blood changes, pathology, and symptoms of polycythæmia rubra vera, which throws a clearer light on the relationship of the various blood diseases to erythroblastic activity than has ever been previously accomplished.

It is gratifying to find reference to the admirable work of Drs. E. P. Poulton, Hunt and Cambell on the cyanosis of heart failure, which is explained as being due to capillary stasis as the arterial blood in such cases is almost saturated with oxygen.

Finally, reference may be made to the rôle played by the large spleen in Vaquez-Osler disease. The author believes the enlargement to be a protective mechanism in that it functions (1) as a blood reservoir to relieve the state of permanent plethora, and (2) as a powerful hæmolytic agent whereby the disease is limited. On theoretical grounds, therefore, splenectomy would be contraindicated, a consideration fully borne out in practice.

A Textbook of Special Pathology. J. Martin Beattie, M.A., M.D. and W. Carnegie Dixon, M.D., B.Sc., F.R.C.P. Second Edition. (Messrs. Heinemann. 1921.) Price 31s. 6d.

The post-war revision of this popular textbook has been completed and a second edition has now appeared. This volume goes in detail into pathological conditions of each separate viscus, and should prove of even more value to the student than its companion volume on "General Pathology." It is best, however, to read the two volumes together; neither is complete without its fellow. A new edition of the volume on "General Pathology" appeared some months ago, and together the two volumes now provide a concise, up-to-date and readable textbook of pathology.

Practical Physiological Chemistry. By J. A. Milroy, M.A., M.D., and T. H. Milroy, M.D. (Messrs. W. Green and Son). Price 21s. net.

The third edition of this book has been revised, with the addition of chapters of value to Senior Students of Physiological Chemistry.

The book does not require more than an elementary knowledge of either inorganic or organic chemistry from the reader, and we are glad to see that not only is the reason for a chemical reaction fully explained, but each reaction is accompanied by chemical formulæ.

Another valuable point about this book is that all the sources of possible error are clearly demonstrated, and not left as stumbling blocks to the puzzled student.

For senior students the new chapters dealing with the quantitative side of the subject, such as H ion concentration, analysis of urea, sugar, amino-acids, etc., in blood, are welcome.

This carefully written book has been brought completely up to date, and has been especially compiled so as to be of use in clinical medicine. The useful tables and the coloured plates of spectra at the end complete a valuable book which gives an intelligent account of the practical side of Physiological Chemistry.

Golf.

For the half-year (July 1st—Dec. 31st) the following members have won the Monthly Medal :—

July ...	F. J. Smith	... 88–12	75
August ...	R. Hughes...	... 93–18	75
September	R. Hughes...	... 3 down,	
October ...	J. N. O'Rafferty	... 98–24	74
November...	D. G. Bown	... 101–24	77
December...	J. P. Evans	... 101–16	85

In addition to the above a prize of half-a-dozen golf balls was given for the best card returned between November 3rd and December 14th. This was won by :—

D. G. Bown ... 101–24 77 nett.

The following suggestions were brought before a general meeting on November 1st last. The suggestions met the approval of the meeting and were signed by Dr. Cameron (President) :—

1. That no member shall have his handicap reduced until the Handicap Committee think it necessary.

2. That the Handicap Committee shall consist of four members. The following were elected ;—

D. B. Whitlock, C. Greenway.
F. W. Schofield. F. J. Smith.

3. That the West Kent Golf Club (Chistlehurst shall be the Hospital course.

I should like to draw the attention of all members of Guy's Hospital Golfing Society to the facilities offered to students by the secretary (Mr. Traylen) of the West Kent G.C. Members wishing to join this club may do so at a very reduced figure. The membership fee per annum is £7 7s., payable on May 31st. Members wishing to join from January to May may do so at the rate of £3 10s., and then pay their annual subscription. The West Kent course is a thoroughly sporting one, and is in easy access of London, I cannot speak too highly of the splendid way this club treats our members, and I feel sure that those who have played there for the last few months will agree on this point.

For the benefit of new students and others who play golf I should like to draw their attention to the notice-board in the colonnade, on which is a list for additional names for those wishing to become members of G.H.G.C. It is hoped that all who can will sign the list.

The Monthly Medal Round will in future be played on the last Wednesday in each month. It is hoped that as many members as possible will make an effort to play on this day. There will be a game of some kind every Wednesday. Matches will be posted as soon as arranged.

The S.E. & C. Railway Co. will allow members of G.H.G.C. to travel to Chislehurst at the rate of 2s. per head (return) provided twelve members travel together.

On behalf of our Society I should like to congratulate Kenneth McKenzie on his success in the "Daily Mirror" tournament, open to London football clubs, and as "Footballer Golf Champion" should like him to join us any Wednesday.

In conclusion, I should like to ask all members if they will please "tick off" as soon as possible after each new list is posted.

F. J. SMITH,
Hon. Sec.

Football.

GUY'S v. CARDIFF.

Undoubtedly the Hospital XV. on December 17th performed at Cardiff the most notable feat of any Hospital Rugby XV. With R. F. H. Duncan, E. E. Neser, L. K. Watson, W. H. Taylor and P. G. Harvey and C. L. Steyn all absent Guy's overcame Cardiff, the side that is almost unbeatable on its own ground and before its own crowd, and one may almost say, at its own style of play. For many years Wales has been the great exponent of the threequarter back passing game and on this occasion Cardiff passed as well as ever, and they crossed our line as many times as we did theirs, but Daneel secured the victory for Guy's by converting both the tries. The pace of our threequarters was greater than the pace of Cardiff's back division and we played five threequarters, at the point of final attack therefore we had on occasion a man to overlap. The handling was excellent, and so was the defence of both sides. During the first half Grant, in a forward rush, gained a try, which was not added to, for Cardiff. Our defence had been sorely tried at times and several anxious moments were experienced.

The second half saw some brilliant running and passing by the Guy's men. Bekker and Sprong kept their attacking quintette moving and at length Graham-Davies got over the line, Daneel doing the needful. All the forwards did well, in the tight they held up, and breaking away quickly, tackled with vigour. Cardiff came on again and again, but Guy's were the first to add to the total, Doherty gaining the try. Daneel again goaled. Cardiff replied, Roche following up a drop at goal very speedily and securing the touch. Wallace converted.

There must have been quite 10,000 people at Cardiff Arms Park, and the game was generally voted one of the best ever played in Cardiff. The spectators appeared thoroughly to appreciate the fare provided—and Cardiff know good football when they see it. Our men were heartily applauded whenever good play warranted it and a truly great game ended—Guy's 2 goals (10 points), Cardiff 1 goal 1 try (8 points).

Guy's team—E. J. Crisp, A. Daneel, P. K. Albertijn, H. Graham-Davies, J. G. Van Schalkwijk, A. Hirschberg, F. Bekker, E. L. Sprong, W. D. Doherty, E. H. Fouraker, F. J. Biddle, G. Zondagh, R. N. Cookes, N. Holloway, H. G. Hutchinson.

GUY'S v. OLD ALLEYNIANS.

Several men being in need of a rest on December 10th, a side well diluted with reserves represented the Hospital for this match at Honor Oak Park. For once even Bekker and Van Schalkwijk decided to watch the game. Both these men are ever ready to play for the Hospital and their relaxation was surely well earned. It was good to see Doherty in the field again, he is of course an Old Alleynian. They, the visitors, were not at full strength either, and Schlund, their most frequent scorer, was in the centre instead of on the wing.

The first half was fairly well contested the Old Alleynians putting in some good work as far as the pack was concerned. We were in this department without W. H. Taylor (who was leading Cornwall in their match with Gloucester), R. F. H. Duncan and E. F. Fouraker, the last named also an Old Alleynian. Meacock, once the forwards heeled out, was quick at getting the ball away and found Sprong as a rule, but the last named still suffers from slowness off the mark. To pass standing still is poor work and no gain. After a few minutes play P. K. Albertijn dropped a neat goal. After this Daneel gained a couple of good tries for both of which Albertijn worked the opening though Daneel should be given every credit for running finely. A couple of penalty kicks against us were poorly taken; and some extraordinary misdirected kicks by Van Heerden helped the Old Alleynians more than Guy's. Blanche and Muriel were good forwards for the Old Alleynian's, while Dixon, whose appearance caused amusement, seemed imbued with a great wish to floor Albertijn. Ere half-time arrived the Old Boys made one grand forward rush, but nothing came of it. Daneel's second try was splendidly converted by Neser and ends changed Guy's leading by 12 points to nil.

The second portion of the game developed into a personal triumph for Albertijn and into a sad falling away on the part of our visitors. They tackled most poorly, but our backs were on their best game. Meacock, Sprong, Albertijn and Daneel. Van Heerden was uneven, and Hirschberg did not have much done for him. Jacobsz at back struck one as a player to watch when the test of his ability would be higher. Neser got one try this second half. Albertijn five, his running, swerving and side stepping, and that magnificent "dummy selling" of his, sent him time after time bang through the opposition. Daneel had a couple more tries and five of this last lot of tries being converted, the margin of our win was 7 goals (1 dropped) and 4 tries or 46 points to nil. The old forwards, or rather the regular forwards, were sound as usual, none more useful than Biddle, who, in the tight or heavy work, does more than his share. R. Cookes, showed promise and will do well.

Guy's Team—J. S. Jacobsz, A. Hirschberg, H. Van Heerden, P. K. Albertijn, A. Daneel, E. L. Sprong, S. P. Meacock, W. D. Doherty, E. E. Neser, F. J. Biddle, G. Zondagh, L. K. Watson, P. G. Harvey, G. G. T. Tregarthen, R. Cookes.

GUY'S v. OLD MILLHILLIANS.

While the 1st XV. were doing so well at Cardiff the "A" with one or two from "B" team proceeded to fairly put it across the Old Millhill Boys at Honor Oak Park, on December 17th.

Some re-arrangement became necessary on the ground, the Captain, A. Van Niekert being away; Cameron therefore filled the vacant place at three-quarters, and Readers gallantly filled up the pack.

The game was somewhat uneven at first the forwards taking some minutes to settle down, but soon H. K. Williams sprinted away and passed inwards, Walters did not accept, but Cameron was in attendance and dribbling on he scored. Williams with a good run gained the next try and James the third. Williams was in good form and appeared much faster than of late. None of these 3 tries was majorised, and the same lack of success followed a try obtained by Anderson of the Old Millhillians. Anderson followed up a lofty kick with too much speed for the defenders.

After half-time the same line of play was followed, *i.e.*, getting the leather to the right wing, Williams, and three times he ran in. Once the other wingman was successful, gaining the touch rather wide of the posts. Only two goals were kicked, L. B. Helder and O. R. Jones being the successful place kickers. It was very regrettable to learn that James, who retired damaged about five minutes from the end, had broken a collar bone. He had played very well, running both straight and strongly. Jacobsz had little to do, all the threequarters handled well and ran strongly; we cannot remark on their tackling, they had none to do. The forwards did not play anything like so well as they ought. One was slack and one was very poor at getting down to the scrums; Eckhoff was pluck personified. Helder the pick of them all with Schabort a good second. Meacock deserves much praise. He did his proper job splen-

didly and with every rush, and in all the loose work, he was with the forwards and never far from the the ball. The final score was, Guy's 2 goals 5 tries (25 points), Old Millhillians 1 try (3 points).

Guy's Team.—J. S. Jacobsz, H. K. Williams, H. J. Walters, G. C. Cameron, J. Leslie, S. P. Meacock, O. P. James, L. B. Helder, J. A. Currie, J. T. Schabort, C. F. Morrison, C. Ive, H. L. Eckhoff, A. Russell and — Readers.

GUY'S v. ROSSLYN PARK.

Not a very great crowd witnessed this match at Honor Oak Park on Saturday, December 31st. Many students had not returned from their holidays and it was feared that regular supporters had trekked to Blackheath, who were playing Cardiff. Several forwards were away. Steyn, who was but recently in the wards, pluckily turned out, but not unnaturally he was not at his best. His tackling being of the negative kind. One hopes his recovery will be as complete as it has been rapid. The game was quite young when McBride, a very powerful threequarter, ran in for the Park. It was an opportunity of which McBride made the most. Misfortune soon befell the visitors though, as their full back was hurt in tackling Hirschberg. One felt sorry for Dawson, but it was refreshing to notice the determination of Hirschberg's attempt. Albertijn brought the scores level; he appeared to sell many dummies on his way to the line. It was a very clever try. Van Schalkwijk next took a penalty kick just inside the half-way line and dropped a magnificent goal. Our forwards, who seemed "Christmasy," were not doing so well as Rosslyn Park, and soon our territory was invaded. Here, right in front of goal a penalty was awarded Rosslyn Park, and McBride, who seemed always in the picture, kicked a goal. Sprong, whose worth is proved in every match and who would be a much better player still if he would get off the mark quicker, next intercepted and broke clear, Van Schalkwijk took in the situation at once and backing up took a pass from Sprong to run to the posts and goal himself. Delightful movements were stopped by the Park men tackling till just on half-time, Hirschberg running with plenty of power got in by the corner flag. This made the score 14 points to 6.

After half-time our forwards tired and Rosslyn Park pushed them about somewhat unexpectedly. Bekker found himself awkwardly placed. Saunders, a speedy winger, next came away from his own half, and Steyn didn't go for him, so Saunders easily gained a try, 14 points to 9 points. Then McBride, who was never dull for long, dropped a very neat goal, 14 points to 13 points. From now on play was very determined and a great sense of relief spread itself when Sprong got clear away from a scrum by the line and scored a try which was unconverted. Result:—Guy's, 1 placed goal, 1 penalty and 3 tries (17 points).; Rosslyn Park, 1 dropped goal, 1 penalty and 2 tries (13 points).

It isn't fair to criticise players at this particular season of the year. The visitors were much stronger than last season and made us go all out. Pauw, short of training, turned out to lend a hand, and of the other newer players Schabort was very useful.

Guy's Team.—E. J. Crisp, A. Hirschberg, J. G. Van Schalkwijk, P. K. Albertijn, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, R. F. H. Duncan, L. K. Watson, F. J. Biddle, R. V. Cookes, —. Schabort, A. Pauw.

Specialities.

PLASMON, LTD., 66a, Farringdon Street, E.C.4.

It is now some twenty years since the Plasmon Company first manufactured this Invalid Food, which is a good milk preparation, and the fact that to-day it is more widely in demand than at any time previously, is sufficient proof of the appreciation it has received.

Plasmon is the casein of milk carefully prepared by a simple process, which separates the proteid from milk serum, and when dried the analysis shows it contains 90 per cent. of pure proteid.

It thus forms an excellent food for Invalids, nourishing and easily digested.

In combination with Plasmon the following preparations are made by the Company which will be found serviceable:—

Plasmon Beef Extract, Plasmon Arrowroot, Plasmon Cocoa, and Plasmon Oats.

Samples of Plasmon and other preparations may be obtained on application at the above address.

Publications Received.

(With apologies for any inadvertent omissions.)

Abstracts of Bacteriology, The Antiseptic, Architectural Association Journal, St. Bartholomew's Hospital Journal, The Broadway (*Westminster Hospital Gazette*), *Burma Medical Times, Current Research in Anæsthesia and Analgesia, Galmahra* (*Magazine of University of Queensland*), *Indian Medical Record, London Hosiptal Gazette, New York State Journal of Medicine, New Zealand Journal of Health and Hospitals, Otago University Review, The Stethoscope, The Serpent, The Goldsmithian, The Hospital Gazette, The Hospital and Health Review, University College Hospital Magazine, Odontologische Revue, Health, The Prescriber, St. Mary's Hospital Gazette.*

Marriage.

ELMSLIE—BENNETT.—On January 2nd, 1922, at Putney, Noël Elmslie, of 26, Springfield Road, St. John's Wood, to Mabel Clara Bennett, of Brooklyn Nursing Home, 321, Upper Richmond Road, Putney.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE recommendations of Lord Cave's Committee on Hospitals are now beginning to have effect, and there is every reason to hope that the tide of financial distress is on the ebb, and that the year 1922 will be one of increasing prosperity for the voluntary hospitals.

Some criticism has been levelled at the action of the Government in cutting down the £1,000,000, recommended by the Cave Commission, to £500,000, and in making the provision of relief conditional upon the raising by the impoverished hospitals themselves of a sum of money equal in amount to the grant. Hospitals that have been for years past sparing no effort to raise enough funds to maintain themselves as voluntary institutions, will not find it easy to collect still more money, in order to justify the allocation of a grant to relieve their distress and help to wipe out their deficits. But it must be borne in mind that the conditions upon which grants are allowed are calculated to apply to the relief of financial stringency without at the same time involving the sacrifice of the voluntary principle. The Cave Commission has shown clearly that it considers the voluntary system worth saving, and the methods adopted by the Government are certainly well suited to the preservation of this principle.

Of the grants which have so far been allotted, none has been received by either the London Hospital, St. Bart.'s, St. Thomas's, or Guy's. It must be assumed that the other hospitals among which an emergency grant of £77,900 has been distributed have been able to produce evidence of more acute financial distress. But the four great hospitals mentioned above are in urgent need of assistance, and it is hoped that part of the £180,000 which the Hospitals Commission have appropriated for London will be devoted to their aid.

As regards Guy's, it is anticipated that the accounts for 1921 will show a well-marked deficit, in spite of the efforts which have been made to raise new funds. Of these, the appeal to the in-patients in the wards to contribute towards the maintenance of the Hospital has been remarkably successful. Although only about one-third of the in-patients have been in a position to contribute, their offerings have amounted to no less than £6,000. With this, and the other schemes now under consideration, there is every reason for confidence in the future of Guy's. Once our deficit is abolished, and the money required to pay off indebtedness incurred in capital expenditure on buildings is obtained, our finances will have a secure

foundation, while the income of the Hospital will be augmented by voluntary contributions from those patients who are able to help, and from other sources. Then we shall be able to stand on our feet unaided, and to fulfil our Founder's dream of a great voluntary hospital instituted for the relief of the sick and suffering poor.

THE new list of students' appointments is now out, and we are forcibly reminded of the new conditions which have arisen in the Hospital, owing to the large numbers of men now entering the wards, or already doing clinical work. The days are gone when every dresser or ward clerk had as many beds as he could deal with. Now there are dressers and ward clerks in swarms, and the parcelling out of work results in each man having only two or three beds to look after.

It is true that there are only five senior dressers on each firm, in lieu of the statutory six, but apart from this fact, there is a real danger of overcrowding, and the drawing in the College Smoking Room, depicting a struggling mass of men forming a scrum around a bed, while the disgusted clerk to the case stands aloof and murmurs in weary accents, "I wish they'd heel out a bit quicker," is likely to prove only too accurate in its application to present conditions.

We understand that, in future, the number of senior dressers attached to each firm is to be limited to six. As considerably more than 24 men will be applying for a senior dressership every three months, the effect of this limitation will be to make the appointment a competitive one, and only the best men will be appointed, the remainder being doomed to another three months as junior dressers in completion of their compulsory appointments.

One matter about which a good deal of discussion has arisen is the question of dressings in the female wards. During the war, owing to the paucity of dressers, this work was undertaken by the nurses, and the experience they gained in doing it was of the utmost value to them.

In some wards these dressings are still done by nurses. While we recognise that it is necessary for a nurse to be conversant with the technique of dressings, it is even more imperative that the medical student should learn to do the work efficiently, and we feel that the time has come to return to pre-war conditions, at least while the number of dressers is so large. To take the case of a junior dresser—it is quite conceivable that at present such a dresser may have charge of two beds only, one in a male and one in a female ward. If he does not dress the wound of the female patient, he is losing half of his already diminished work, and half of the skill and experience he should be acquiring. He may, later on, have charge of a surgical ward and be required to superintend the after-treatment of surgical cases. He must, therefore, lose no possible opportunity of gaining that experience which can only come through the actual performance of dressings.

Overcrowding, again, seems imminent in other directions. Soon there will be more externs than can possibly be needed. How these men are going to conduct twenty labours each—the requirements of the Conjoint Board of Examiners—is a problem which still presents some difficulty.

The age of competition has come upon us. Every single student will have to do his utmost to gain experience; the medical ward clerks must not confine their investigations to their meagre three beds; the dressers must lose no opportunity of doing all they can; for the war is over and experience is becoming more and more difficult to obtain. Only the best men will get the best appointments. In the realm of medical education, as in the broader kingdom of Nature, only the vigorous and the healthy personalities survive.

We publish on page 33 an article containing extracts from Mr. Leopold Wagner's account of the "Ship and Shovel," which appeared in *Mine Host*, in November, 1921. The historical details mentioned in this account are sure to interest the many Guy's men who have, in their time, foregathered in this ancient inn, there to quaff ambrosial nectar and recuperate after the arduous labours of the day.

One item of information which is new to us is contained in the statement that the annual bonfire, which was, until recently, such a spectacular *finale* to the celebrations of the Christmas week, and which provided such a warm welcome to the oncoming year, was originally instituted by Thomas Guy himself as a protest against the activities of the builders who made Maze Pond the wilderness of bricks that it is to-day. We are told that Guy made the burning of a bricklayer's hod and wheelbarrow obligatory on the part of the students, as an expression of his anger at the spoliation of so fair a scene as the Maze Pond was in those days.

Whenever we find ourselves ignorant as to some little historical anecdote about the Hospital, some choice *morceau* of antiquarian lore, we turn for aid to our "Wilks and Bettany," a book which abounds in stories of Guy, and of the early Hospital Physicians and Surgeons. (In this very issue we publish some verses by a contributor who derived inspiration from this same collection of biographies.)

But when we seek to elucidate the mystery of the bonfire's origin, we appeal to Wilks and Bettany in vain. They have given us no record of any such pyrotechnic efforts on Guy's part. Mr. Wagner's story is, therefore, of particular interest, and we appeal to Guy's men who are interested in old ceremonies associated with the Hospital, to lighten our darkness, if they have any further information upon the subject.

The sale of the Guy's Hospital Christmas Cards printed by Messrs. Ash & Co., realised the sum of £40 13s. 2d. In accordance with their usual generous custom, Messrs. Ash & Co. have devoted the proceeds of the sale to the benefit of the Hospital funds, and this sum has been handed to the Hospital.

We offer our hearty congratulations to Mr. A. J. McNair, who was successful at the recent examination for the Diploma of Fellow of the Royal College of Surgeons.

The lure of the footlights has once again yielded to the more Spartan attractions of the playing fields, and football has come into its own. Neither the Rugby XV. nor the Soccer XI. seems to have suffered from the brief hiatus in the fixture list between 1921 and 1922. Indeed, both seem to have started the second half of the season with renewed energy, judging from results. Although we cannot claim an unbeaten record, even in 1922, for the Rugby team, Bristol only attained their revenge for their defeat at Honor Oak Park, after a very strenuous and evenly-contested game, while the Old Merchant Taylors, Royal Air Force, and Cambridge University all suffered defeat at our hands.

The Soccer XI. are to be congratulated on two notable victories. They have beaten the H.A.C., hitherto invincible, by 1—0, and they have defeated St. Bart.'s by 3—0 in the Second Round of the London University Challenge Cup Competition.

We wish them every success in their match against King's College Hospital in the Semi-Final of the same Competition. It is to be hoped that as many as possible will make a point of being present at this match. Association Football at Guy's does not, as a rule, attract so large a crowd as Rugby, but we trust that the most enthusiastic support will be given to our Soccer XI. when Cup Ties are being played. Inter-Hospital Soccer Cup Ties are also soon to take place, and should be well attended.

We wish to draw attention to the fact that the "barracking" of referees at matches is not calculated to add lustre to the good name of Guy's, or to enhance our reputation for

sportsmanship. One would have hardly thought this protest necessary, but facts have proved that it is. In our recent Rugger match against the R.A.F., at Honor Oak Park, a certain section of the Guy's supporters behaved in a manner usually associated with the more violent partisans of professional football teams. The culminating incident in their performance occurred when one of the R.A.F. players failed at a goal kick after a creditable attempt. While the issue was still in doubt there was silence. When it was seen that the kick had failed, these men actually *cheered*. We regret to say that some of them were Guy's men, and not merely casual spectators at the match. We can only hope that they feel ashamed of themselves and that they will not repeat their offence.

While dealing with this subject, we cannot refrain from expressing the hope that at future Cup Tie matches Guy's spectators will not allow the practice of counting out the score aloud to become a habit. It was a fairly regular occurrence last year. As each try was scored by the Guy's team, Guy's supporters would shout out the score in unison, counting until the right number of points was reached. When we are well ahead, such a practice rather savours of hitting a man when he's down. When we are not, why waste breath about it?

We congratulate Mr. R. F. H. Duncan on his selection as Reserve for England, and Mr. H. Graham-Davies on being chosen as Reserve for Wales, in the forthcoming International match.

In the cartoon which we reproduce in this issue, our artist ably depicts incidents behind the scenes at the Residents' Play which is shortly to be produced. (We are glad to say that we were wrong in our doubts as to whether rehearsals had started. They have!) Our artist's work is of such an essentially topical nature that we have used it, not as a frontispiece for our 1922 volume, but bound in with the letterpress of this number. We invite any artist who can produce a sketch suitable for a frontispiece to submit his effort to us.

Events of Interest for Fortnight ending February 4th.

Jan. 21.—Rugby, Guy's "B" v. Blackheath "B" at Honor Oak Park.

Association, Second Round Surrey Cup, Guy's v. Croydon High School Old Boys.

Jan. 23.—1.30 p.m., Clinical Lecture by Mr. Eason. "The use of the Ophthalmoscope in the General Medical Wards."

5 p.m., Hunterian Lecture at the Royal College of Surgeons. Prof. Sir A. Keith on "The European Face and its chief variations in type."

Hockey, First Round United Hospitals Cup, Guy's v. St. Thomas, at Dulwich.

Jan. 25.—4 p.m., Lecture at Royal Institute of Public Health (37, Russell Square.) "Laboratory aids to the diagnosis of Tuberculosis infection."

5 p.m., Hunterian Lecture at the Royal College of Surgeons. Prof. Sir A. Keith on "The study of certain aberrant types, Bushmen, Eskimo, Lapp, Ainu."

Rugby, Guy's "A" v. Downing College, Cambridge (away).

Jan. 26.—5.30 p.m., University of London Union Society's Debate at Essex Hall. Chairman, Rt. Hon. J. H. Whitley (Speaker of the House of Commons). "That the University Man will, in future, play a less prominent part in the life of the Country."

8 p.m., Pupils Physical Society's Joint meeting with St. Thomas' Hospital Physical Society.

Jan. 27.—5 p.m., Hunterian Lecture at Royal College of Surgeons. Prof. Sir A. Keith on "The facial characteristics of the races native to India."

7.45 p.m., Beggars Dance at Knightsbridge Hotel.

Jan. 28.—Rugby, Guy's v. Gloucester at Honor Oak Park. Guy's Nomads v. Kings College School, Wimbledon (away).

Association, Guy's v. Old Westminsters, at Honor Oak Park.

Jan. 30.—12 noon, Clinical Lecture by Dr. Iredell on "Diathermy."

Feb. 1.—Clinical Lecture by Mr. Rowlands.

4 p.m., Lecture at Royal Institute of Public Health. "The virulence of Tuberculosis Bacilli and the circumstances under which it may vary."

Rugby, Guy's "B" v. Royal Veterinary College at Honor Oak Park.

Feb. 4.—Rugby, Guy's v. Blackheath (away). Guy's Nomads v. Park House "C" (away).

A Case of Acute Yellow Atrophy.

E. B., a boy aged 12 years, had recovered from an attack of scarlatina six weeks before admission. He was quite well, except for some hypertrophy of the gums, till ten days before admission when he complained of general malaise and became jaundiced. Six days later he commenced vomiting, his general condition became worse, and he was compelled to go to bed. On the morning of the day of admission he complained of slight headache; the jaundice had increased in intensity to a dark orange, but he was in much the same condition as he had been during the last four days. Suddenly, at 1.30 p.m. he became delirious and extremely violent and began shrieking out; the jaundice began to subside rapidly till, when brought to Hospital at 5.30 p.m. it had almost completely disappeared.

On admission he was delirious, extremely restless even to the extent of being violent, and intolerant of any interference. He frequently gave wild, single, sharp shrieks which were so like the "hydrocephalic cry," that a student who was "warded" diagnosed him as meningitis as he was brought into the ward.

Systematic examination was out of the question. Temperature 102·6; pulse 128; respiration 18.

There was no muscular rigidity or head retraction; rather, the head was flexed upon the chest and the knees were bent up into the abdomen and patient chose to lie on one side. Kernig's sign was not present. The plantar reflexes were flexor. The abdomen was not retracted, and no abnormality was detected on palpation. Eye signs were not present. Nothing was found in the mastoid regions. A cursory examination of the chest revealed nothing. There was no perceptible jaundice. No specimen of urine was obtainable.

He was given Haustus Chloral 1 dr. soon after admission.

At 8.30 p.m. a lumbar puncture was performed and 5 c.c. of fluid withdrawn. The cerebral-spinal fluid was not under tension; it was found to contain no abnormal cell count, no increase in protein and no micro-organisms.

At 2 a.m. next day, the pulse dropped from 130 to 72; patient gradually passed into a state of stupor and died at 3.20 a.m.

At autopsy, the tissues and body fluids were found bile stained. There were petechial hæmorrhages beneath the pleura, pericardium and peritoneum. Altered blood was present in the œsophagus and pharynx. The brain and meninges were normal. The liver was of about normal size, somewhat soft, opaque and yellow, and interspersed with red patches. The finding of "acute yellow atrophy" was confirmed by microscopical examination.

A Case of Paraplegia.

G. T., aged 40 years, a schoolmaster, was admitted into Hospital with the following history:—

Four months before admission he commenced having bilateral pain of a severe nature in the small of the back. This pain gradually disappeared some six weeks before admission, and was succeeded by a definite girdle pain, and by weakness of the lower limbs which rapidly developed into an inability to walk, so that within three days of the disappearance of the indefinite vertebral pain he had lost completely the use of the lower limbs. He then lost sphincter control and became bedridden.

On admission patient, who was a pale, thin, weak-looking man, was found to have a flaccid paralysis from about the umbilicus downwards, with loss of all sensations, reflexes and sphincter control. There was an angular curvature in the region of the 7th dorsal spine, over which there was some tenderness. A mass of glands were palpable in the left side of the neck above the clavicle; these had been present for 12 months. The base of the left lung was dull; T.V.F. was absent and voice sounds were diminished. A large bed-sore was present in the sacral region. R.E. revealed nothing. The Wassermann Reaction was negative.

For two months patient remained in much the same condition, with the exception of his cough, which became progressively worse. It was noticed that the glands in the neck had become more discrete, and small nodules appeared on the ribs in various situations. Later, the spleen became palpable. Patient then developed a left sided pleural effusion, after which bed-sores rapidly developed and he steadily declined and died.

The interesting feature in this case is the diagnosis, and to arrive at it three cardinal points have to be co-related:—

1. A flaccid paraplegia.
2. An angular curvature of the spine.
3. A mass of glands in the neck.

The following conditions should be considered in the differential diagnosis:—

1. Fracture dislocation of the spine from injury.
2. Hæmorrhage into the cord or membranes.
3. Spinal caries.
4. Pressure by a growth.
5. Pressure by an aneurysm.

The first, the most common cause of a complete transverse lesion of the cord was eliminated by the absence of a history of injury.

Hæmorrhage into the cord results only from trauma, or bleeding into a syringomyelia. As there was no evidence of either, the second possibility was eliminated.

The rarity of compression of the spine by aneurysms and the suddenness and completeness of the lesion tended to eliminate the last condition. Moreover, the absence of a history of V.D. in an intelligent man, and the negative Wassermann contra-indicated any syphilitic lesion.

Spinal caries is the condition which superficially permits of the most logical interpretation of the sequence of events in this case. There was an angular curvature suggesting Pott's disease. This is a condition which can, and not infrequently does, produce compression effects upon the spinal cord resulting in a paraplegia. This diagnosis would agree with the level of the paralysis and would be consistent with glands in the neck, a liability to pulmonary affections and the general poor condition of the patient.

Pressure by growth remains to be considered. The types of growth which, in the male, produce such symptoms are:—

1. Secondary carcinoma of the prostate.
2. Metastases of hypernephromata.

And more rarely:—

3. Secondary carcinoma of glands such as thyroid and pancreas. These had been excluded clinically.

Growth of the testes (carcinomata) are said to produce metastases in bone; probably they do so much more rarely than is generally believed. Nevertheless, the testes were examined and nothing abnormal found.

The enlargement of the spleen one would as soon attribute to some chronic infection such as tuberculosis as to growth—a rare occurrence in the spleen.

All this tends to indicate spinal caries as the most likely diagnosis. There are, however, certain points in the history and in the progress of the condition which should, and did, cast some doubt upon this diagnosis. They are:—

1. The history and nature of the spinal disease.
2. The rapidity of the onset of the paraplegia.
3. The size and progress of the glands in the neck.
4. The presence of the swellings on the ribs.

The occurrence of spinal disease for the first time in a man of this age should have cast some doubt on the inference that the angular curvature was due to Pott's disease; for the latter rarely makes its appearance in the adult in such a severe form as to produce an angular curvature.

The next point is probably the most important. Spinal caries produces paraplegia not by collapse of the vertebræ and consequent compression on the cord, but from pressure by tuberculous inflammatory products. The production of a complete paraplegia by this agency must of necessity be a slow process. In this case, however, complete paralysis had developed within three days.

The glands, if carefully considered, are definitely against the suggestive diagnosis. If they were tuberculous they would, before reaching the size they did, have shown some signs of caseation or breaking down. Moreover, the fact that they became more discrete should have led one away from tuberculosis, for in this condition the tendency is for the mass to become more adherent and the individual glands less discrete; and the only explanation for what occurred here is to consider that the glands contained growth and that as the outlying ones became infiltrated they became palpable and the mass apparently became more discrete; and the swellings on the ribs would bear this out.

At autopsy a large mass of growth was found in the region of the 7th and 8th dorsal vertebræ which had produced discontinuity of the vertebral column. The ribs were infiltrated with growth, several nodules being palpable within and without the thorax. The mass of glands in the neck contained growth. The liver contained a number of large, hard nodules showing mucoid degeneration at their centres. This appeared to be so like secondary carcinoma that the whole of the gastro-intestinal tract, the prostate, the testes—in fact all the viscera and even the breasts were diligently but fruitlessly examined for a primary growth. The spleen contained a number of nodules of secondary deposits. There was a left-sided, clear, pleural effusion of 2½ pints; the lung was collapsed, but contained no new growth.

Unfortunately, the parts kept for microscopical examination (which did not include the prostate) showed growth which was not sufficiently typical to allow of a dogmatic opinion as to its nature.

I am indebted to Drs. Hurst and Symonds for permission to publish these notes.

MAURICE MITMAN.

Pass List.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES. December. 1921.

P. Berry.
D. G. Brown.
E. T. Clifton.
H. W. D. Crook.
H. S. Gaussen.
W. G. Porter.
J. D. Reas.
E. S. Rudaizky.
S. D. H. D Wallis.
J. K. G. Way.
L. S. Williams.

University of Cambridge.

THIRD M.B., PART II. December, 1921.

W. R. Carling.

PART I.

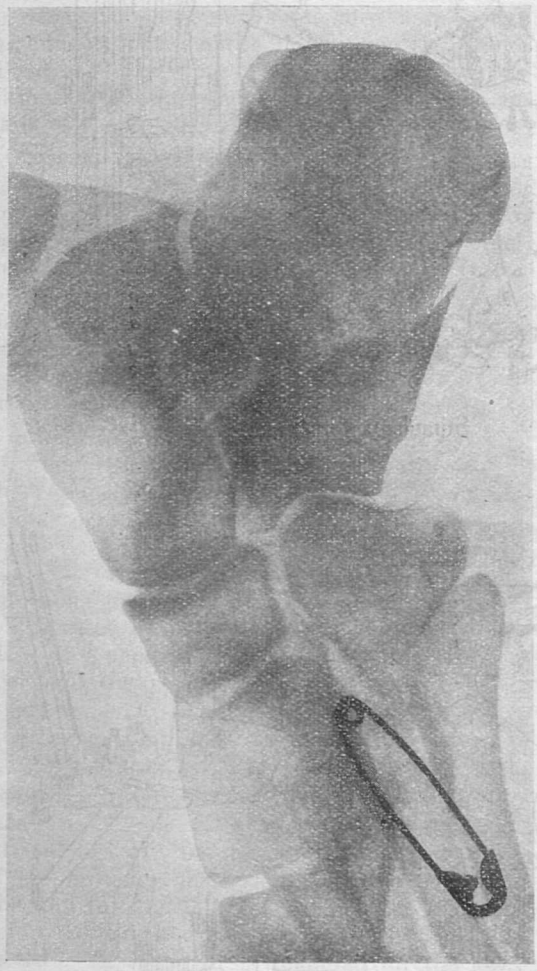
R. Traill.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Fracture of Os Calcis.

DEAR SIR,—Cases of fracture of the os calcis are so uncommon that this one appears worth recording.



Mr. A., aged 52, height 6ft., weight 13 stone, fell from a height of about nine feet, or rather leapt to avoid a fall from a slipping ladder, landing on his feet. He felt a snap in the left foot and found the heel of his shoe torn off. When seen a few hours later there was great swelling and effusion of blood about the ankle. Crepitus was noted during manipulation. The ankle joint was movable and there was no lateral displacement of the foot.

X-ray examination showed as in the accompanying prints. An antero-posterior skiagraph showed a normal ankle joint.

There was no fracture of tibia or fibula, no injury to knee, hip or spinal column. The displacement (as shown in the prints) was negligible and the only treatment adopted was rest with a flexed knee, and elastic compression with cotton wool.

In spite of an ecchymosis blister, the swelling soon subsided and massage was begun on the second day. Four weeks after the accident he could stand on the affected foot. There was some paræsthesia about the heel and "pins and needles" over the foot on pressing behind and below the internal malleolus.—I am, etc.,

G. H. PENNELL.

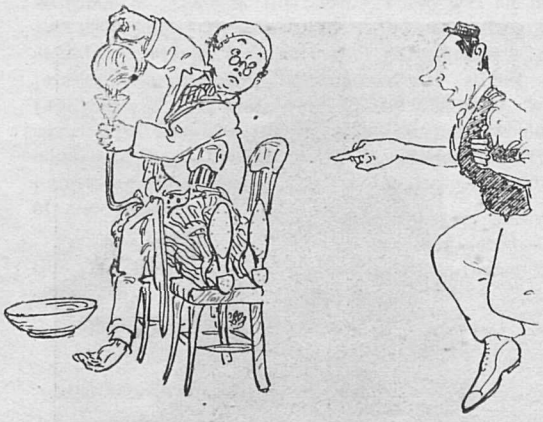
January 8th, 1922.

The skiagraphs were taken at the Edenbridge Cottage Hospital.

Change of Address.

Martin Braun, National Bank Chambers, Short-market Street, Cape Town, South Africa.

E. G. Slesinger, O.B.E., M.S., F.R.C.S., from 2, Devonshire Place and 10 Lauderdale Mansions, to 69, Wimpole Street, W.1. ('Phone: Mayfair 3177.)



A Performer misses his Call.

Stimulants for Stage Fright.

Comparing Likenesses.

Finishing Touches.

BEHIND THE SCENES AT THE RESIDENTS' PLAY.

(By our Official Artist, Mr. Keith Watkinson).

Decapsulation of the Kidneys in Subacute or Chronic Parenchymatous Nephritis.

CLINICAL LECTURE BY DR. J. FAWCETT.

GENTLEMEN,—Decapsulation of the kidneys as a form of treatment in subacute or chronic parenchymatous nephritis was once more brought prominently to my notice on hearing Dr. Francis Boyd, at the meeting of the Association of Physicians in Manchester in 1920, narrate the details of a case under his care.

Only in recent years has this group of cases been looked upon as lending itself to surgical treatment, although a considerable number of cases of renal disease often somewhat vaguely spoken of as "nephritis" have been treated by surgical methods. In consequence of this loose classification it has proved difficult to obtain satisfactory data on which to base an opinion of the value of "decapsulation" in true "nephritis."

I want to impress upon you that in speaking of "nephritis" I mean "Bright's disease" of the parenchymatous type, and not cases of unilateral or bilateral disease of the kidney secondary, for example, to pyelitis or pyelonephritis, from a calculus, a "bacillus coli" infection, or other similar causes, many of which cases have been loosely included in the class of "nephritis" and so resulted in confusion of the issue.

The next point I wish to impress upon you is that decapsulation is not to be regarded as a form of treatment to replace the older methods, unsatisfactory though they be in many cases, nor is it to be undertaken nor advised lightly. A thorough prolonged course of the ordinary methods must be carried out first, and full time allowed to judge of the effect, before advising the surgical treatment here suggested. This caution is rendered all the more necessary because we know that some cases of "nephritis," apparently of a most intractable type, suddenly begin to improve and continue to progress for no obvious cause, so far as we can determine. We recognise that this event takes place in many diseases, and the longer our experience the greater are the numbers of these happy occurrences.

Thirdly, the greatest care must be exerted in selection of cases, as otherwise you will do more harm than good and bring discredit on a measure of treatment of real value if its limits are strictly guarded. Further definition of its limits will be referred to later, and all I will say for the present is that decapsulation affords relief in some cases of "nephritis" which do not react to other forms of treatment.

With these warnings before you and the general remarks on the boundaries of the treatment, I will now give you short details of Dr. Francis Boyd's case (vide *Edinburgh Medical Journal*, February, 1921), and then proceed to those of the patient who forms the subject of my clinical lecture to-day.

Dr. F. Boyd's patient was a miner, æt. 41 years; he was admitted to the Royal Infirmary, Edinburgh, in September, 1916, complaining of swelling of the legs and abdomen, and of breathlessness. Nine months previously the patient, while at his work, had suffered from pain in the back, which was present only when he was actually at work. About this time he became more easily tired and suffered from severe headaches. The pain in the back gradually became more severe and the headaches worse, necessitating cessation from work a fortnight before admission. Latterly the eyes, face and ankles began to swell and then the abdomen and legs. The patient had hitherto been a strong man, temperate in all ways.

On examination he was a well developed muscular man. The legs were enormously swollen, and the abdomen distended with free fluid.

Urine.—Quantity on an average 20 ounces per diem; specific gravity 1023. Albumen, 32 grains to the ounce. No sugar. Numerous hyaline and granular casts present. There was considerable cardiac dilatation. "Systolic" blood pressure 130.

The blood showed a mild secondary anæmia. The soluble nitrogen of the blood was 60 mg. per 100 c.c. of blood. The abdomen was tapped at once and the patient placed upon a nitrogen-free diet, but the amount of urine passed did not increase, and the fluid re-accumulated. "Salt-free" diet and "dry" diets had no effect and the patient remained in a water-logged state. Diuretic drugs also failed to produce any alleviation of the condition.

Between September and the following January 119 pints of fluid were evacuated from the abdomen, and 13 pints from the legs. A

progressive failure of the circulation was taking place and the condition of the patient was becoming more critical. It was obvious that something must be done if the patient was to obtain relief. The patient gladly accepted the suggestion of operative treatment.

Accordingly an incision was made into the capsule of the kidneys along its diameter, and the capsule stripped from both sides of the kidney. Very little urine was excreted on the day of operation, but the following day the patient passed 55 ounces; 70 ounces on the third and fourth; and after this an average of 70 to 80 ounces until the œdema had disappeared. Ten days after the operation the quantity of albumen had fallen to 2·2 grains per ounce. Progress was uninterrupted, and the patient was discharged on February 3rd. He was then passing about 50 ounces of urine a day with albumen 1·2 per cent. After a short period at home the patient returned to work, getting a light job on the surface. When last heard from, he had been working uninterruptedly for three years. There was still albumen in the urine, but the heart had quite recovered its tone, the condition of the circulation was satisfactory, and the patient expressed himself as feeling well.

I will now show you the patient who is the subject of my clinical lecture to-day. The operation was performed rather more than six weeks ago. Perhaps his eyelids are still a little puffy, and, as you can see, some œdema of the legs and of the back persists, although considerably less than before the operation. He has lost his sallow pallid complexion and he expresses himself as feeling better, a good deal better indeed in his own opinion than in ours, although we have no doubt that great improvement has occurred. A large amount of albumen is still present in the urine.

H. M., æt. 39 years, a hawker, was admitted under my care on March 16th, 1921, with headache, difficulty in breathing, and general œdema. He had been quite well during his period of service in the army and had been demobilised about a year before admission. No record of any previous illnesses.

Present illness.—Began about two months before admission with what was said to be "influenza and bronchitis." The patient had been "in and out" of bed ever since. The œdema was first noticed about five weeks before admission in both lower and upper extremities, and for about a similar period the urine was stated to have been dark-brown in colour; micturition, too, had become painful and about a week before admission he had suffered from anorexia and headache which became gradually more severe, nausea, and at times vomiting. The patient also said he was passing only about half a pint of urine a day. He complained that when lying down in bed he "could not get his breath."

Condition on admission.—The man had a sallow and pallid complexion. There was anasarca, the legs, scrotum, and back being œdematous in particular, and the eyelids were swollen. Over the lungs the respiratory murmur was of a "wheezy" type, and râles were audible here and there. The cardiac impulse was defined with difficulty, just in, or internal, to the left nipple line in the fifth intercostal space; the cardiac sounds were normal. There were no physical signs of disease elsewhere except in the kidneys, and no retinal changes. The blood pressure, maximum systolic, was 160 mm. Hg.

Urine.—Specific gravity 1025. A considerable amount of albumen and of blood present. Microscopically epithelial and granular casts as well as red blood cells were found. Albumen 10—14 per 1,000 (Esbach). Quantity of urine per day at first 20 to 30 ounces.

"Blood urea" 0·92 grammes per litre, or three times the normal. The "Wassermann" reaction was negative.

Diagnosis.—Subacute tubal nephritis with some interstitial change; uræmia.

Progress.—In the course of a month the hæmaturia disappeared; the œdema was less and also the headache and dyspnœa. Forty to fifty ounces of urine were now being passed in the day, but the quantity of albumen remained high at 8—10 parts and more per 1,000 (Esbach).

April 12th.—"Blood urea" was reduced by nearly one-half, viz., to 0·48 grammes per litre.

May 3rd.—An "urea concentration" test was carried out after the administration of 15 grms. of urea, when the excretion of it was found to be very deficient, as at the end of two hours there was only 1·04 per cent. urea present. In a normal person the percentage of urea should be 2 to 3 per cent. In addition to the large amount of albumen, numerous hyaline and granular "casts" were found.

The patient remained in hospital until June 15th, 1921, that is for three months in all. The œdema fluctuated considerably, gradually becoming less, and by the time of discharge there was little when the patient was recumbent, although on assuming the erect posture the œdema reappeared slightly in the legs. A satisfactory feature was that the "blood-urea," before the patient left the hospital, had fallen to normal, viz., 0·29 grms. per litre. The quantity of albumen, however, had not diminished, and although the general condition of the patient had improved materially, and the anæmia had disappeared, yet we felt almost sure that a relapse would occur shortly.

We had tried all the usual methods of treatment, in the acute stage a diet largely composed of milk, imperial drink and saline purges. Also a "salt-free" diet, and the usual medicinal measures. Two and a half weeks after admission the patient was given a farinaceous diet and two eggs, and at the end of a month fish was added.

We did not give him a diet rich in protein—a diet to which some of the cases of "tubal nephritis," with persistent anasarca will react and lose their œdema—because of the very deficient way in which he excreted urea when tested by the "urea concentration" test, and also the high "blood-urea" in the early stages of his illness.

Before proceeding further I should like to say a few words in regard to the diagnosis. That the main change in the kidneys was a "tubal" one was shown by the presence of general persistent anasarca, and the large quantity of albumen in the urine. That, however, there was some "interstitial" change in addition was shown by three pieces of evidence—a slight enlargement of the left ventricle, a higher blood pressure than normal for a man of 39 years of age, viz., 160 mm. Hg. max. systolic pressure, and the defective way in which the urea was excreted. These latter features as evidence of "interstitial renal" change rendered us hesitant in advising surgical interference, and less hopeful of obtaining such a good result as might have been looked for if the case had been of a less "mixed" type.

During the month of May there was a gradual improvement in the health of the patient, the headaches and other uræmic symptoms disappearing and also the œdema almost completely. 50—60 ounces, and more at times, of urine was passed in 24 hours, but the amount of albumen remained high, 10—12 parts per 1,000 (Esbach), and numerous hyaline and granular casts with some fatty granules were found in the centrifugalised deposit.

The "blood-urea" content became, later on, highly satisfactory, viz., 0·29 grammes per litre, a normal amount.

At the patient's request he left hospital in the middle of June, but after two or three weeks the œdema reappeared and continued to increase until on August 8th he was back in hospital. Although the œdema of legs, back and trunk was now as extensive as on the previous admission, yet the patient was not so ill, inasmuch as the headache, the nausea and the vomiting and dyspnœa, the "uræmic symptoms" of the disease, had not reappeared. Another most satisfactory feature was that the "blood urea" remained at the same figure, a normal one, as in June, and within three or four days of admission the quantity of urine passed rose to 50 ounces in the day.

Dr. Ryle, who had seen the case with me on several occasions previously and who was in charge of my beds in August, then called Mr. Turner into consultation, as we had decided to ask the surgeon's help, should the patient relapse.

On August 23rd Mr. Turner operated and stripped the capsule from both kidneys. The kidneys are described as of a large size, that is larger considerably than healthy kidneys. The patient recovered rapidly from the operation, and within three or four days the œdema was considerably less, and by September 9th there was œdema of lower parts of legs and ankles only. The quantity of albumen was less, 7—9 parts per 1,000, as compared with 10—12 parts formerly. Then the condition became stationary for the time. Although the patient improved very much in his general health during his further stay in hospital, yet he did not get rid altogether of the œdema.

Later Note.—He was discharged at his own urgent request on November 27th, 1921. There was slight œdema around ankles, and the amount of albumen varied from 5 to 8 parts per 1,000 (Esbach). Quantity of urine passed in the 24 hours was on the average about 80 ounces. I have since heard from Dr. Ryle, who sees him regularly at Out-Patients, that the man's condition remains satisfactory.

Remarks.—There was no dramatic improvement in this patient like that which occurred in Dr. Francis Boyd's case. Nevertheless, great amelioration did occur and the patient in particular was convinced of the advantage which had accrued to him from the operation. He had almost lost his œdema, he felt quite well once more, his appetite was good, his organs were performing their functions well on the whole. We, however, bearing in mind the caution expressed in the earlier part of this lecture, to the effect that even apparently hopeless cases of "nephritis" with dropsy may suddenly take a turn for the better, were not so convinced as was the patient. Yet when we consider how hopeless is the outlook of many of the cases of chronic tubal nephritis with general anasarca, how that ordinary measures of treatment after a prolonged trial effect little good, how that there was without a doubt a striking improvement not only in the anæmia and general health of this man, but in the signs of the "nephritis," I think you will agree that we were abundantly justified in the course we recommended the man to pursue. Time alone will show whether the progress will continue, and we hope to be able to keep an eye upon the man in the "Out-Patient" Department of the unit. Probably one reason for the fact that the patient did not advance so far, or so rapidly, as otherwise he might have done, was the presence of cardio-vascular change and interstitial "nephritis" in addition to the predominant "tubal" nephritis.

It is for you to remember that with cardio-vascular degenerative changes, and even comparatively slight signs of interstitial nephritis, such good results are not to be looked for, as in cases of parenchymatous or tubal nephritis. Nevertheless there are cases in which you may deem it desirable to adopt surgical means of treatment, as in the case of the man I have been speaking to you about to-day, even though the prospect of success is less favourable where "interstitial" change is present.

But where there are grounds for believing that chronic interstitial changes exist, you must very seriously consider the position before recommending operation. From this it follows that if the condition is one of advanced "granular kidney" in your opinion, with the "blood urea" high and the secretion of urea deficient, operation is contra-indicated absolutely and should not be undertaken.

In order to illustrate further the essential points in deciding upon the class of case suitable for operation, I will refer shortly to a series of four cases reported by Sir T. Horder in the *B.M.J.*, for November 13th, 1920. Two of these cases were of the subacute or chronic parenchymatous variety and two of a "mixed" type with "interstitial" changes.

Case 1.—A man of 39 years of age giving a history of increasing œdema of the lower extremities for four months. The case was a typical "parenchymatous nephritis." The man was anæmic, with a puffy face. Urine, 30 ounces passed in 24 hours containing 2·5 per 1,000 albumen; epithelial and granular casts present. Blood pressure 120.

The œdema diminished under the usual treatment by rest, a "salt-free" diet, diaphoretics and diuretics, and he was discharged relieved.

Some ten months later he was re-admitted, and, as usual, worse than before, and no improvement took place from six weeks' further treatment.

Sir D'Arcy Power operated upon the patient with the result that a rapid amelioration of the man's condition ensued. In two weeks the œdema had disappeared and the excretion of urine had reached a normal level. In six weeks albumen and "casts" were no longer found, although a trace of albumen reappeared later. The patient was operated upon in 1914, and five years later he appeared in excellent health and there was no albuminuria.

In the second case, a child of 10 years of age, a good result was also obtained, though less rapidly.

And now let me refer to one of the two cases in which there was considerable evidence of "interstitial nephritis." The patient was a captain in the Army, æt. 29 years. Ten months previously he was said to have had "influenza" followed by hæmaturia, frequent and painful micturition, headache, malaise and nausea. After a week he was allowed up, and went "on leave," his condition having improved. Then the "nephritis" recurred, and he was treated for four months. At the end of that time there was no œdema, except of the eyelids in the morning. The output of urine was 30 to 40 ounces daily, and the urine contained 2 parts per 1,000 of albumen, a number of red cells, and a few granular casts. In addition there was some hypertrophy of the left ventricle, as judged by a heaving cardiac im-

pulse and a booming first sound. The blood pressure was 175 to 185. The capsules of both kidneys were stripped off at the operation. After a week the puffiness of the face had gone, and the urinary secretion had increased to 60 ounces a day. A month later the urine still contained red cells and hyaline and granular casts, and 1·5 parts per 1,000 of albumen. A year later the blood pressure was still high and there was no change in the condition of the urine. Although this man was better in certain ways, he had not improved to anything like the same degree as the previous case.

Thus you will appreciate from the resumé of these cases the great importance, the necessity, of trying to determine as exactly as possible the variety and the degree of "nephritis" with which you have to deal, and that if "interstitial nephritis" and cardio-vascular changes exist, the prospect of relief from operation is diminished, and the more so the more marked these changes; also that only after mature consideration of the case as a whole should operation be recommended in this type of case, and certainly not at all if the changes are well marked.

The difference in prognosis depends possibly upon the fact that in the chronic "interstitial" cases the changes which take place are progressive and accompanied by progressive cardio-vascular changes, whereas in subacute or chronic parenchymatous "nephritis" the "poison" which originally produced the "nephritis" may have been got rid of to a large extent, or even altogether, with the result that "decapsulation" affords the kidneys an opportunity to recuperate if performed before extensive fibrotic changes have taken place.

The treatment cannot be looked upon as perfection, far from it, but for some carefully selected cases which are slowly but surely slipping downhill it offers a meed of help and one worthy of trial.

To those of you who are interested in the technique of the operation I may say that in the earlier period of treatment by mechanical methods the kidneys were in some cases punctured or incised, on the hypothesis that the tension within the capsule is relieved thereby, whereas more recently the kidneys have been lifted from their bed, the capsules stripped off, and the kidneys then returned to their place. I noticed in the reports of some cases in the same number of the *Edinburgh Medical Journal*, (February, 1921), as that of Dr. Francis Boyd's, that Mr. John Fraser, of Edinburgh, recommends that the capsule of one kidney only shall be stripped at a sitting, although both should be decapsulated.

The rationale of the process, how and why it does good, is unknown, although, of course, various suggestions have been made, including the relief of tension, the formation of new vessels between the viscus and the surrounding tissues which provide new channels whereby inflammatory products may be removed, and so the kidneys re-establish wholly, or in part, their functions.

"The Ship & Shovel," Bermondsey.

[Mr. Leopold Wagner, in the November issue of *Mine Host*, has given an interesting account of the old Southwark inn. The extracts quoted below are reprinted by kind permission of the proprietors of *Mine Host*.]

Few, if any of the old inns in the Metropolitan area, can surpass the "Ship and Shovel" in location amid historic surroundings, or interest to the antiquarian. True enough, "The Bricklayer's Arms," and "Ye Olde Tabard" are better known to the general public, on account of their associations with the great Naval Commanders and the Canterbury Pilgrims, but neither of these conjures up, like this haunt of Guy's men from time immemorial, visions of "pleasant fields and meadows, bleating sheep and browsing kine, shady walks, a clear stream spanned by a stone bridge, a monster labyrinth or maze, and a stretch of ornamental water, with ducks and swans, the existence of which is perpetuated by the name of the thoroughfare, Great Maze Pond."

Originally the whole of the region from this point eastwards to Horselydown and Rotherhithe belonged to the Abbots of Battle, in Sussex, whose town house stood on the site of the present Battle Bridge Lane, off Tooley Street.

The only building to mar the prospect was a mill, formerly identified by Mill Lane, where the Abbots utilised the watercourse for the grinding of their own corn. With the arrival of the Huguenots in England, however, all this was changed.

"Then," as Mr. Wagner says, "the work of upheaval commenced in real earnest. Little by little the vernal sward and the pretty fieldpaths became parcelled out into tanyards with unsightly sheds appertaining to the hide and skin industry. The ground having thus been broken, these were destined

to develope into huge warehouses as we behold them to-day, and anon both the maze and the pond vanished, leaving naught but a name to tell the tale of bygone natural beauty. So much pained, indeed, was Thomas Guy, the founder of the great Hospital and Medical Schools opposite the parent institution of St. Thomas of Canterbury, which migrated to the Albert Embankment in June, 1871, at this spoliation of the fair scene, that as a perennial expression of his displeasure he made it obligatory on the part of the students to 'ring in the New Year' by the public burning of a bricklayer's hod and wheelbarrow in the courtyard. Of the true origin of this quaint custom there can be few Londoners other than Guy's men qualified to speak. . . . "

There is no mention of this behest in Wilks and Bettany's History of Guy's Hospital, but there is a striking account of the rural surroundings of the Hospital in 1738. Snow's Fields *were* fields in those days, and in other directions meadows extended southwards for a considerable distance.

Guy's was a remarkably healthy hospital in spite of the fact that, at that time, a great ditch, which drained land and houses all the way from the Kent Road, ran past it towards the river. This may be attributed partly to the fact that open fields were at hand.

To return to the "Ship and Shovel"—we read in *Wilks and Bettany* that Dr. Addison used to take his students in a semi-serious, amateur sort of walk, to the "Botanic Gardens," by the "Ship and Shovel."

As regards Guy's association with the famous inn, Mr. Wagner says, "Equally indisputable is the association of old Guy himself with the 'Ship and Shovel,' for though reputed to be a miser, he had a keen taste for home-brewed ale and fresh crabs, which, in the form of sandwiches, are still the *specialité* of the erstwhile riparian 'house of call,' ere the arches of two great railway stations blotted out the river view from Tooley and St. Thomas's Streets. Moreover, as the son of a lighterman and coaldealer of Horselydown, he could hardly have disdained to hold converse at first with its *habitués*; and one cannot but think that, discovering the cosy parlour to be the regular haunt of St. Thomas' students, whose names are inscribed on the mahogany table still in use there, he formed the pious resolution of founding a hospital which 'The Ship and Shovel' might overlook."

Here we must interrupt Mr. Wagner for a moment to point out that the position of Thomas Guy the elder was more well-to-do than his designation might at first sight indicate. Coal was brought to London chiefly by sea in those days, and the possession of lighters involved a considerable expenditure. We may think of the elder Guy as a prosperous tradesman or merchant.

Mr. Wagner continues: "At all events, Guy's Hospital became an accomplished fact, and to-day its hatless students muster in the self-same parlour just as those attached to the monastic foundation did well-nigh three centuries ago! . . . So far from its sign making a special appeal to men connected with barges and small river craft, in allusion to the shovels used for taking in or removing ship's ballast, it really perpetuates the memory of a famous English Admiral who was lost at sea on the night of October 22nd, 1707. Originally designated 'The Pig and Whistle,' this snug little inn had a great fascination for Sir Cloudesley Shovel when on land, until at last he thought fit to play the part of 'Mine Host' in cherished possession thereof familiarly calling it *his ship*. Unhappily after rejoining the Fleet and crowning himself with further honours he, in the course of sailing for home, struck the rocks of Scilly and perished with all on board. Therefore, out of shere veneration for another of England's naval worthies the time-honoured 'Pig and Whistle' assumed the fresh sign of 'The Ship and Shovel,' and as such it is locally renowned to-day."

A Legend of Addison.

(With apologies to the Rev. Richard H. Barham).

[A (partially) true story—*vide* Wilks & Bettany: History of Guy's Hospital.]

Dr. Addison paced the ward;
His back was straight, his eye was stern,
His black stock went as stiff as a board
From his angular chin to his shoulders broad;
His clerks required no more to learn
That their chief was getting decidedly bored!
For Hodgkin had done P.M.s that day
And only remarked in his cheery way
That the skin was very pigmented, no doubt,
And had pushed the kidneys down the spout
With one fell swoop of his clumsy hand
And thrown away the adrenal gland!

Dr. Addison paced the floor
His eye was stern, his back was straight,
For there was nothing he hated more
Than waste of time:—he softly swore
(Physicians used to in days of yore),
For all his firm had turned up late.
They had been for hours in the colonnade,
Judging the horse flesh there displayed
Just as the ward clerk now discusses
The ins and outs of the surgeon's "busses,"

When up there came with a hullaballoo
The junior clerk in the deuce of a stew,
And this was the tale he proceeded to tell—
"Tommy's in Stephen,* and swearing like H—ll!"

With one accord they rushed to the ward
And were promptly "told off" by their furious lord.
Then the latter proceeded to see those who needed
A name to the ills that their bodies had breeded.
And there was one among the crowd
Who, with eructations loud,
Did most bitterly complain
Of "a nasty, nigling pain."
And Dr. Addison tried in vain,
With all the force of his mighty brain
To diagnose the fellow's lesion.
(He hadn't heard the word "adhesion.")

He thumped his front, he thumped his back,
He looked at his throat, till his face went black,
He felt for liver, he felt for spleen,
He talked of similar cases he'd seen,
And then again his chest he thumped;
But strange to say, even great Dr. A.
Had to admit he was utterly stumped!

* * * * * * * *

It was the witching hour of night
(Dear reader, I know very well you are right
The phrase is perhaps not original—quite),
And all was quiet in Stephen Ward,
The patients slept, and most of them snored,
Except for the man with the pain in his tummy
Who kept making noises decidedly rummy.

Sister Stephen had gone to bed,
In a bit of a huff—she'd a pain in her head.
The Arabella of these days
Had checked the chloral and gone her ways,
(She used to go to bed at ten,
"H.P." wasn't invented then),
And nurse was giving the Haustus Chlor.
When who should come blundering in at the door
But Dr. Addison—half undressed,
Furtively trying to hide his vest,
And nurse, whose manners were quite of the best
Said, "Dr. Addison! well, I'm blest!"
But this was all the great man said,
"I remembered, the moment I got into bed
That I had forgotten the simplest of things—
I never examined his inguinal rings!"

Moral—

This rhyme has a moral for everyone here,
All cases abstruse will be perfectly clear,
If you don't get put out by absurd little things
And always examine the inguinal rings.

*not the present ward.

Notices.

Charles Murchison Scholarship in Clinical Medicine.

The next Examination for this Scholarship will be held at the Royal College of Physicians of London, on Monday, the 12th day of June, 1922, and *following days.*

The Examination is open to any Student of Medicine, whether holding a Medical qualification or not, who, subsequently to the date of passing his professional Examination in Anatomy and Physiology for a Medical qualification, has studied for a period of not less than two and a half, and not more than five, years at a Medical School in London, recognised by the Royal College of Physicians, or at the University of Edinburgh, including Medical Classes recognised by the Medical Faculty of the University.

The Examination will be conducted both orally and in writing, and will include—

(a) Examination of Patients, with reports on their cases.
(b) Questions on Pathology and Treatment, and
(c) Examination on Specimens.

The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than May 29th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools, and evidence of the date at which they passed their examination in Anatomy and Physiology.

(The Examination for 1923 will be held in the University of Edinburgh.)

J. A. ORMEROD, M.D.
Pall Mall East, S.W.1. *Registrar.*
January, 1922.

Metropolitan Asylums Board.

COLINDALE HOSPITAL, HENDON, N.W.9.

Applications are invited for the appointment of Junior Assistant Medical Officer (unmarried). The vacancy is at Colindale Hospital, Hendon, N.W. 9, which accommodates 271 male adults suffering from pulmonary tuberculosis.

Salary £422 per annum with bonus in addition. The present rate of bonus is £93 6s. per annum, but is subject to revision.

Preference will be given to candidates under 30 years of age. Special knowledge of tuberculosis is not essential provided that candidates are otherwise suitable.

The candidate appointed will be required to reside in the Institution and to pay for board, lodging and washing at the rate fixed from time to time by the Board's Finance Committee. At present the rate is £130 per annum.

Applications to be made not later than 10 a.m. on Saturday, 28th January, on forms obtainable from the Clerk, Metropolitan Asylums Board, Embankment, London, E.C.4., by forwarding stamped addressed foolscap envelope.

DUNCOMBE MANN,
Clerk to the Board.

Office of the Board,
Embankment, E.C.4.
9th January, 1922.

Appointments.

Guy's Hospital Medical School.

January 16th, 1922—April 15th, 1922.

Clerk to Medical Unit (Second three months).—(Dr. Fawcett) Messrs. W. H. Craib, G. T. Henderson, L. G. Housden, Emrys Jones, C. F. Keast, M. Myers, G. O. Millis, G. W. Y. Parry; (Dr. French) Messrs. J. B. Bell, W. A. Caldwell, G. C. Mitchell, P. Mc. G. Moffat, E. E. Neser, F. N. Newell-Roberts, A. T. W. Powell, S. C. Rowbotham, D. Vaughan; (Dr. Beddard) Messrs. A. B. Aldred, J. A. Currie, A. B. Davies, G. F. Gibberd, J. Jemson, H. C. C. Taylor, T. R. Blacklidge, T. A. Shaw, D. J. T. Jeans.

Dressers to Surgical Unit (Junior Dressers).—(Sir Alfred Fripp and Mr. Turner) Messrs. D. H. Berry, L. W. Cann, R. D. Gross, R. E. Lane, S. A. Leader, F. Marsh, O. G. Morris, E. Wornum; (Mr. Steward and Mr. Hughes) Messrs. R. S. Chambers, J. C. G. Dickinson, J. F. Goodenough, J. C. Hewetson, H. Maclachlan, C. H. C. Toussaint, S. C. H. Worseldine, H. D. Wyse; (Mr. Fagge and Mr. Davies-Colley) Messrs. F. W. Annis, R. J. Cann, G. C. Hughes, R. Macintosh, L. E. Owen, W. F. Payne, I. R. Vermooten; (Mr. Rowlands and Mr. Bromley) Messrs. A. M. H. Ashwin, W. H. Bradfield, C. W. Greenway, I. H. Horwitz, C. Ive, S. P. Jacobson, D. S. Todd-White; (Mr. Slesinger) Messrs. H. G. Close, A. S. H. Douglas, M. B. Seng, J. L. Le C. Walker.

(Senior Dressers).—(Sir Alfred Fripp and Mr. Turner) Messrs. H. G. R. Canning, M. Hawke, H. E. Killard-Leavey, D. G. Robinson, M. Weinbren; (Mr. Steward and Mr. Hughes) Messrs. R. H. Amm, M. Bannounah, C. Bowen, J. L. Faull, D. B. Hitchings; (Mr. Fagge and Mr. Davies-Colley) Messrs. H. P. Baylis, J. A. F. Dennyssen, H. Seelenfreund, F. E. Graham-Bonnalie, R. G. Tame; (Mr. Rowlands and Mr. Bromley) Messrs. N. L. Eckhoff, N. L. Lloyd, M. Mitman, G. D. Shaw, T. Wooldridge.

Obstretric Dressers, Externs and Clerks in Children's Department.—(Mr. Bellingham-Smith) Messrs. H. C. Beccle, H. L. Bernstein, A. Broido, D. A. L. Crawshaw, S. H. Daneel, H. Evans, A. Gordon, P. G. Harvey, J. H. M. Lloyd, H. J. Plowright, F. J. Smith, R. M. Still, J. L. Woodhouse; (Mr. Chapple) Messrs. W. G. Booth, W. A. Brown, C. O. Carson, P. Hack, I. F. Harries, R. J. Hooker, D. H. Hubbs, H. C. Meathrel, E. Orsmond, A. F. Percy, S. Suzman, C. W. Warne, G. B. Withers.

Dressers or Clerks in Special Departments—

Ophthalmology.—(Mr. Eason) Messrs. H. T. Chiswell, W. G. R. Hore, L. H. B. Macleod, H. Richards and P. G. Sedgwick; (Mr. Ormond) Messrs. F. D. Howitt, R. Hale-White, J. S. Hudson, C. O. Kark, D. G. Sharp and W. M. Ramsden.

Laryngology.—(Mr. Mollison) Messrs. F. D. Howitt, R. Hale-White, J. S. Hudson, C. C. Kark, D. G. Sharp and W. M. Ramsden; (Mr. Layton) Messrs. H. T. Chiswell, W. G. R. Hore, H. Richards, P. G. Sedgwick and F. W. Widgery.

Neurology.—(Dr. Symonds) Mr. H. A. H. Harris.

Genito-Urinary.—(Mr. Thompson)

Orthopædics.—(Mr. Trethowan) Messrs. H. A. H. Harris, H. B. Jones and H. Richards.

Fractures.—(Mr. Slesinger) Mr. H. B. Jones.

Dermatology.—(Dr. Barber).

Clinical Assistants.—(Dr. Hurst) Messrs. T. E. Jones, B. L. Laver, M. Mackenzie, J. K. Milward and M. E. Shaw.

Clerks to Anæsthetists.—(January 16th—February 15th, 1922)—

Monday—

Mr. E. A. Scott (Mr. Fagge)—Messrs. V. R. De Boissiere and K. W. Mackenzie.

Tuesday—

Dr. Shipway (Mr. Steward)—Messrs. G. E. Fisher and S. C. Bakhle.

Mr. Marston—Messrs. C. H. Atkinson and B. C. Woodroffe.

Assistant Anæsthetist (Mr. Rowlands)—Messrs. J. Atkin and M. Markiles.

Assistant Anæsthetist (Mr. Trethowan)—Messrs. J. S. Hudson and F. M. Ratnagar.

Thursday—

Dr. Shipway—Messrs. G. E. Fisher and S. C. Bakhle.

Mr. Marston—Messrs. C. H. Atkinson and B. C. Woodroffe.

Mr. E. A. Scott—Messrs. V. R. De Boissiere and K. W. Mackenzie.

Friday—

Dr. Shipway—Messrs. J. Atkin and M. Markiles.

Mr. Marston—Messrs. J. S. Hudson and F. M. Ratnagar.

Dental O.P.'s (Morning).—

Monday—

Mr. Todd—Messrs. J. Atkin and M. Markiles.

Tuesday—

Mr. Scott—Messrs. V. R. De Boissiere and K. W. Mackenzie.

Wednesday—

Mr. Bailey—Mr. G. E. Fisher.

Thursday—

Mr. Marston—Messrs. C. H. Atkinson and B. C. Woodroffe.

Friday—

Mr. Scott—Mr. S. C. Bakhle.

Saturday—

Mr. Marston—Messrs. J. S. Hudson and F. M. Ratnagar.

Reviews.

Nerve Exhaustion. Sir Maurice Craig, C.B.E., M.D., F.R.C.P. (Messrs. J. and A. Churchill.) Price 6s. net.

There exists, perhaps, no subject in medical psychology of such paramount importance to the general physician as that of nerve exhaustion. It is encountered in, and forms indeed a serious complication of manifold somatic disturbances which are only too apt, by the very urgency of their manifestations, to conceal the mental disorder which may yet exert a baneful influence on the course of the initial disease.

It is, therefore, with pleasurable anticipation that one turns to this work, written by so distinguished an author.

In reading the section on the causation of nerve exhaustion, one is struck by the immense varieties of factors which may lead to this state. The author's views on recreation and education here expounded are of particular interest. He points out the folly of advising active bodily exercise to those who are on the verge of a break-down, a practice which will probably rapidly lead to disaster. Again he believes that signs of precocity in a child indicate undue hypersensitivity of the nervous system which may be wrecked by the routine early education of the child, and lead in adult life to mediocrity or serious mental instability.

The symptomatology of this affection is extremely varied. Thus, illusions of memory, homicide, irritability and many other abnormal states may arise from nerve exhaustion. It is, perhaps, unfortunate that the author does not in this connection attempt to probe more deeply into the underlying factors which result in one or other of such disease symptoms. Many such have been shown to be due to symbolic expressions of repressed desires, the liberating agent being, in all probability, the state of exhaustion produced by environmental stress.

Lastly, in dealing with the treatment of sleeplessness, the author advances views which should be earnestly considered by all engaged in the practice of medicine. He states very truly that the danger of sleeplessness is far greater than the risk of starting the drug habit, which has in fact not infrequently been commenced by patients as the direct result of the injudicious refusal to prescribe hypnotics by their physician.

The work is, in short, highly commendable in that it helps to bridge that deplorable chasm which has steadily widened between the naturally allied subjects of general and psychological medicine.

There are, indeed, few books more worthy of perusal by both practitioner and student.

Vicious Circles in Disease. By Jamieson B. Hurry, M.A., M.D. Third and enlarged edition, 1919. (Published by Messrs. J. and A. Churchill.) Price 15s.

A statement by Sir Clifford Allbutt is quoted with reference to Vicious Circles in which he says that:—"This aspect of medicine is one which no practitioner of the ars medendi can afford to neglect." This book is the only one entirely devoted to the subject, and after reading it one becomes convinced even more strongly than before of its extreme importance.

Taking the various systems of the body one by one, each illustrated by numerous and striking quotations from a number of authorities, it is shown that the vicious circle is one of the most important mechanisms in pathology.

Since the appearance of the previous edition six years before, nine fresh chapters have been added, much of the original work has been re-written, and evidence is brought forward to show that this mechanism extends to the lower animals and also to vegetable life.

Apart from the extreme antiquity of the phrase "Vicious Circle" the author sees some advantage in Professor J. M. Baldwin's expression, "circular reaction," which has the advantage of being applicable to beneficent as well as injurious processes and is defined as "a condition which keeps itself going by "reproducing the conditions of its own stimulation." Galen about 130 A.D. wrote: "Ulcers of the lung are most difficult to heal; for they cannot be cleansed apart from coughing, and by coughing they are torn further. Thus, owing, so to speak, to a recriprocity of action, the disorder revolves in a circle." This illustration shows how the imperfect adjustments of Nature may be corrected by art.

Dr. Hurry recognises two types of vicious circle, those dependent on disturbed correlations between organs and parts of organs, and those in which the symptoms react injuriously upon the primary disorder. He also demonstrates that there may be multiple concurrent reactions. The processes involved in these, as well as in the simpler types, are illustrated and impressed by very ingenious diagrams.

The section on the nervous system is perhaps of particular interest and value. In neurasthenia irritability begets exhaustion, and exhaustion increases irritability. If insomnia appears as an additional drain upon nervous energy, the circle revolves with increasing speed, and unless tackled early and with energy may become exceedingly difficult to arrest.

Organic fatigue results in mental depression, which in its turn reacts upon the physique. Each depressing thought suggests others, and the increasing or-

ganic irritability accelerates the advent of further anxiety and gloom.

As Dr. A. F. Hurst so often insists the best cure for epilepsy or asthma is not to have them, and this equally applies to other nervous conditions when the laws of habit become arraigned against the physician. "Worry begets worry, attention and hyperæsthesia intensify each other, increase of appetite grows by what it feeds on." One should attempt not only to arrest the accelerating revolutions of the injurious cycle at the earliest moment, but should if possible reverse their direction, and establish beneficent cycles in their place.

From the nervous system the author proceeds to consider circulatory, respiratory, digestive, genito-urinary and other systems in a very interesting and practical manner. Unfortunately, owing to limitation of space we cannot give them even the briefest summary, and must refer the reader to the book itself.

Interesting Cases in the Wards.

Under Dr. Fawcett, Dr. Ryle and Dr. Marshall—

Esther	21.	Splenic anæmia.
	27.	Chlorosis.
	34.	Spastic paraplegia (?cause).
	38.	Hour-glass stomach.
Stephen	30.	?
	36.	Cerebro-spinal syphilis.
	41.	Pernicious anæmia.
	46.	Gumma of liver and testicle.

Under Dr. Beddard and Dr. Mutch—

Esther	9.	Mitral Regurgitation and Stenosis.
Stephen	19.	Aortic Regurgitation.
	20	Aortic Regurgitation.

Under Dr. Hurst and Dr. Symonds—

Addison	11.	Pernicious anæmia.
	32.	Case of obscure anæmia with jaundice.
	46.	Tumour of lung.
Mary	22.	Pernicious anæmia.
Stephen	38.	Tabes.

Football.

GUY'S v. R.A.F.

The above match was played at Honor Oak Park on Wednesday, January 11th, 1922. From every point of view it was a great pity that Surrey and Gloucester's meeting in the Semi-Final of the County Championship was arranged for the same afternoon. Neither players nor spectators could be at both places, consequently the crowd at Honor Oak Park was much less than that expected when the fixture was first arranged. The team, too, was not fully representative. P. K. Albertijn, C. L. Steyn and E. H. Fouraker were playing for Surrey, F. Bekker had exams. on, and W. D. Doherty was called away on duty just before the match. The substitutes did admirably with the exception of some of the forwards who neither pushed nor bustled. The R.A.F. brought a heavy and very strong pack which included Wakefield, the English Cap, Maxwell, the Scotch International, S. P. Simpson, of the Harlequins, and R. H. C. Usher of the London Scottish. C. N. Lowe, for the Air Force, could not turn out, owing to an injury sustained last Saturday.

At first we rather had the flying men in their own quarters. We had the wind and sun at our backs and some of the kicking for touch was very good indeed. Getting quite a full share of the ball the backs handled with precision; still no score came because the tackling of Bryson and W. Jones, the opposing centres, was sound. A line out from touch close up, about 10 minutes before half-time, left Taylor in possession and he dropped over the line for a try. Though wide, Daneel kicked for goal magnificently, the ball hitting the crossbar and falling the wrong side. Later Graham-Davies opened well and passed to Van Schalkwijk, who returned to Daneel, but Maxwell tackled him at once and no addition was made to the score before the interval.

The second half was in favour of the visitors and a temporary inability on the part of the scrum to hold the opposing pack gave Guy's supporters many anxious moments. In addition our tackling was too high, and too full of hesitation. A fine run by Bryson, Jones and J. I. T. Jones, saw the former score and Maxwell's conversion put Guy's in arrears. Great was Meacock's activity behind his tiring front rank, he worked hard; so did Graham-Davies and Sprong. Davies was badly knocked out twice, but with the utmost pluck he returned to the field. Duncan also got outed with Lowe, both being laid out by a "head-on" collision. Happily both recovered and pluckily resumed. Sprong got the try which won us the match. It was a lucky win as we did not have the best of the play. But the side that did duty should be congratulated on upholding the flag in the absence of so many of the regular players. Jacobsz gave a rare good display and Taylor's work was enormous. Neser, as a flying outside, deserves praise. Guy's 2 tries (6 points), R.A.F. 1 goal (5 points).

Guy's Team.—S. Jacobsz, A. Daneel, J. G. Van Schalkwijk, H. Graham-Davies, A. Hirschberg, S. P. Meacock, G. L. Sprong, W. H. Taylor, R. F. H. Duncan, L. K. Watson, F. J. Biddle, F. G. Hutchinson, E. E. Neser, G. Zondagh, R. V. Cookes.

GUY'S v. OLD MERCHANT TAYLORS.

With several men away owing to illness and exams., and with W. H. Taylor and R. F. H. Duncan in the Trial at Twickenham, Guy's fielded a somewhat weaker side than usual. The Taylors were also below strength and did not show that sturdiness among their forwards which has been typical of all packs of Old Merchant Taylors for many past seasons.

The opening was dramatic, the ball being handled as far as H. Graham-Davies, who cut through and

over the line for a try within a very few minutes of the start. Later, but only some 5 minutes later, C. L. Steyn got in on the left; the ball was again worked along the back division till Steyn had a clear run. A very fine kick of Neser's converted this goal. Doherty was the next to go over the Taylors' line, and before half-time Hirschberg gained a try by the corner flag. The last named ran with great pluck and this it was that carried him over. A momentary lull in the zest of the Guy's forwards helped by one or two bad passes from Graham-Davies and Hirschberg got the ball to the other end, where Melhuish kicked a penalty goal, and owing to a mistake on Van Niekerk's part, scored a very soft try. One or two Guy's men, when tackled, pass wildly and without knowledge of their comrade's position. Such passing is exceedingly dangerous. Some very fine kicking by Albertijn and some hefty forward play in which Biddle and Cookes were prominent, ended the first half. Just before the interval Meacock got a nasty kick near the eye and had to go off. As deputy for Bekker, Meacock had played well and it was disappointing that the second half did not see him. Anxious himself to return, he was persuaded to rest as the kick was severe. Van Niekerk was rather uneven, but he had little to do that really tried him. His fielding of the slippery ball was very fine, no catch being missed.

This last half we got four more tries. Fouraker was the first to gain success. Then Steyn sent Graham-Davies away. Beautifully gathering, and full in his stride at once, Davies went for the line in most refreshing style. Though behind the posts, the kick at goal, taken by Neser, failed unaccountably. Albertijn next gained a try, and a very clever one it was. He completely deceived the opposition and ran half the length of the field before crossing near the uprights. Graham-Davies put the ball over the bar for conversion. But a Taylor had touched it en route and no goal accrued. The last try came from splendid handling to Neser, now playing at outside left threequarter. Here again the kick at goal failed and Guy's thus won quite an interesting game by 1 goal 7 tries (26 points), to 1 penalty goal 1 try (6 points).

Guy's Team.— A. K. Van Niekerk, C. L. Steyn, P. K. Albertijn, H. Graham-Davies, A. Hirschberg, S. P. Meacock, E. L. Sprong, W. D. Doherty, E. H. Fouraker, L. K. Watson, F. J. Biddle, E. E. Neser, F. J. Hutchinson, R. V. Cookes, N. G. Holloway.

Hockey.

GUY'S v. WALLINGTON.

In this match, played at Forest Hill, on January 7th, we again defeated Wallington by 6 goals to 3, though playing without Bonnallie and Gathergood. It was a clean and enjoyable game throughout. Scorers for Guy's were Schollum 4, Duckworth and Hunt one each.

Of the Hospital forwards Hunt did some clever things in mid-field. Schollum shot well, and Duckworth at centre, though lacking in speed and shooting ability, played short passing game with good effect.

Slater was the best of the halves, and Bowen of the backs.

ASSOCIATION.

GUY'S v. BART.'S.

(London University Challenge Cup. Second Round.)

This match was played at Winchmore Hill on Saturday, December 17th. Trott was unable to play, owing to injury received in the Hospital Cup-Tie v. Middlesex, so Couch went forward and Parry came in at left half.

In the first quarter of an hour our superiority was very marked, the forwards combining excellently to play delightful football. After Van Geuns and Williams had had shots cleared, Couch scored. Then O'Meara was crocked and Couch had to take his place at centre-half. Shortly after O'Meara returned, both Van Geuns and Couch were badly hurt and for the rest of the game were for the most part passengers.

After the interval Bart.'s attacked strongly, but the tackling of our defence was faultless. Williams followed up a high kick by Wakeford and beating the defence for speed scored our second goal. The weakened forward line were always giving the Bart.'s defence anxious moments, and following a corner one of the Bart.'s full backs put through his own goal.

Result—Guy's 3, Bart.'s 0.

Guy's Team.—E. Hardy, C. A. Wakeford, S. E. Sennitt, O. F. Painter, D. J. P. O'Meara, J. Parry, L. Walters, R. Van Geuns, L. S. Williams, D. H. Couch, M. R. Morgan.

The whole team played well under difficulties, until the two inside forwards were injured; the attack gave a wonderful display of combined work and kept play almost continuously in the vicinity of our opponent's goal.

The defence was good, and by hard tackling seldom allowed the Bart.'s forwards an opportunity of shooting. Sennitt was excellent.

In the semi-final we now meet King's College, who defeated us in the final last season by 2 goals to 1. It is essential that we should have support at this match. When the final was played at Highbury last season King's had 300 supporters and we had less than a dozen, and that on a day when no other Hospital team was playing.

GUY'S v. H.A.C.

Guy's commenced the second half of the season by defeating the H.A.C. on January 14th by 1 goal to nil, at Honor Oak Park. The team are to be congratulated upon thus inflicting upon the H.A.C. their first defeat of this season.

Guy's were without Hardy, Parry and Van Geuns; their places being taken by Wooldridge, Hewetson and Nicolai. The ground was very heavy and the team's success was chiefly due to the fact that they developed wing to wing play. The only goal of the match was obtained in the first half when Nicolai scored after Couch had charged down the goalkeeper's kick.

The H.A.C. forwards were not allowed to play their usual short passing game as a result of the keen tackling of the Guy's halves. Our forwards spoilt many seeming chances by poor shooting and "offside."

Guy's Team.—T. Wooldridge, C. A. Wakeford, S. E. Sennitt, O. F. Painter, D. J. P. O'Meara, J. C. Hewetson, L. Walters, F. Nicolai, L. S. Williams, D. H. Couch and M. R. Morgan.

The forwards accommodated themselves very well to the conditions, but their shooting was poor. Walters played very well, but was unfortunately starved very badly after the interval.

The halves were the outstanding line, their tackling being excellent. O'Meara played his best game of the season, and we hope for repetitions of this form in the coming cup-ties.

The defence was good, both Wakeford and Sennitt playing a very sound game.

Surrey County Senior Cup, Second Round.

This match versus Croydon High School Old Boys has been fixed for to-day (21st inst.) at Honor Oak Park. Kick-off 2.30. We hope to have a full team available.

Specialities.

BENGER'S PEPTONISING POWDERS.

Messrs. Benger's Food, Ltd., Otter Works, Manchester.

Messrs. Benger's Food, Ltd., who are well known for the excellence of their Invalid Foods, are now supplying Peptonising Powders, which will be found most serviceable in preparing Foods for Infants and Invalids.

Full directions for the use of the Powders are given, which, if carefully followed, will render Milk, Beef-Tea, and other articles of Invalid Diet easy of assimilation by those for whom they are intended.

These Powders are odourless, colourless, most effective and readily soluble, and thus may be classed as an excellent Peptonising Preparation. They are also economical.

It may be added that Benger's Food, long recognised as a thoroughly good article of diet for Infants and Invalids, already contains the natural digestive agents, so that it does not require any further addition to effect the digestive changes to make the Food easy of assimilation. These changes occur during the preparation of the Food with milk when it is being made for use.

Messrs. Benger's Food, Ltd., will be happy to forward samples of these Peptonising Powders to medical men on application.

BELL'S UNITED ASBESTOS CO., LTD., Southwark Street, S.E.1

Decolite is a composition flooring containing fibrous asbestos and is made by the above Company.

It has been extensively used for Hospitals, Convalescent Homes, Schools, and other private and public institutions for which it is admirably adapted.

Decolite is warm and comfortable to the tread, thoroughly hygenic, and can be laid on new concrete, and also on existing wood or stone floors.

It is absolutely fireproof, and although only about the same price as linoleum, lasts four times as long.

Those interested can obtain fullest particulars from the above address.

Papers by Guy's Men.

H. C. Cameron, M.A., M.D., F.R.C.P. Hysteria in the Nursery and in Warfare—a Comparison and a Contrast.—*Clinical Journal*, li., 1922, p. 7.

T. Izod Bennett, M.B., M.R.C.P. and Another. Observations on Secretion into the Stomach and Duodenum, with Special Reference to Diabetes Mellitis.—*B.M.J.*, 1922, i., p. 9.

T. G. D. Bonar, M.B., B.S., M.R.C.S. A Note on the Investigation of Gastric Function. Before and After Gastro-Jejunostomy.—*Lancet*, 1921, ii., p. 952.

C. H. Fagge, F.R.C.S. The Value of Blood Examinations in Surgery.—*Clinical Journal*, li., 1922, p. 13.

Alan H. Todd, M.S., B.Sc., F.R.C.S. Common Disabilities of the Feet in Children.—*Ibid.* 21.

R. P. Rowlands, M.S., F.R.C.S. The Value of Freedom and Exercise after Operations.—*B.M.J.*, 1922, i., p. 52.

Publications Received.

Grant Medical College Magazine (Bombay), Nursing Times, St. Bartholomew's Hospital Journal, Architectural Association Journal, The Hospital Gazette, Abstracts of Bacteriology.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Birth.

NEWELL-ROBERTS.—On January 5th, 1922, at Titchling, Hassocks, to Doris, wife of F. N. Newell-Roberts, a daughter.

Deaths

BOSWORTH.—On December 28th, 1921, at Ballincourt, Bexhill-on-Sea, John Routledge Bosworth, M.R.C.S., L.R.C.P., late of Sutton, Surrey, aged 76.

HOLMAN.—After a long illness, Robert Colgate Holman, M.R.C.S., L.R.C.P., a devoted Father, and beloved by all who loved him.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE New Volume of the *Guy's Hospital Reports* has just been issued, and we draw the attention of our readers, once again, to the fact that the *Reports* are issued to unqualified students at the reduced rate of 30s. per annum. Subscriptions should be given to Mr. Winston, in the Wills Library.

It cannot be too strongly stated that students who do not secure a copy of each volume of the *Reports*, as it comes out, are losing a most valuable means of keeping in touch with recent advances in medical and surgical science, and are failing to embrace an opportunity of increasing their knowledge, and stimulating their interest in their profession.

The *Reports* possess for Guy's men an attraction that far surpasses that of other scientific publications. In them are embodied the results of research by men who are known to us, and with whose work we are familiar. When we read them, we assimilate the teachings of those workers with greater ease, we learn to appreciate the lines along which scientific thought proceeds, and methods of investigating diseases, the causation of which is often obscure. Thus our clinical work has for us an enhanced value. In later years those who have not obtained and preserved the *Reports* will lack what should be part of the library of every Guy's man.

The last volume of the old series of *Guy's Hospital Reports* will be published shortly, and will take the form of a War Memorial Volume. This will consist of three parts, the first containing obituary notices of Guy's men who lost their lives during the War; the second a brief epitome of the war service of all Guy's men who took part in the War; and the third articles by Guy's men who had special experiences during the War. A number of copies of the first two parts will be published separately, as it is thought that many relatives of Guy's men who gave their lives may desire extra copies.

The whole volume will be issued free to those students who were subscribers, under the old system, to the GAZETTE and *Reports*, during the period covered by this last issue of the series.

In other cases, and for additional copies, the charge will be 6s. to subscribers and 10s. 6d. to non-subscribers.

THE failure of the English team at Cardiff has caused much speculation among Rugby

enthusiasts as to the changes one might expect in the team for the next International match, and as usual, troops of critics have trotted out their formulæ for the ideal English team—generally with somewhat varying results. One suggestion which we noted with interest was that the next team should consist of a judicious blend of Oxford and Guy's—probably the two strongest clubs in England this season. This anticipation, however, has not proved to be correct, since the only Guy's man who has been selected to play for England is R. F. H. Duncan. We heartily congratulate Mr. Duncan on his selection, and are glad that one Guy's player, at any rate, will represent us in the English pack.

The much-vexed question as to whether overseas players, resident in England, should be chosen for the English team has once again been revived by the *Sportsman*, whose critic quotes a paragraph from "Passim" in which we criticised the inconsistency of selectors. Why should a New Zealander or an Australian be chosen, while a South African is passed over on the grounds that he is not English born? Or why should one South African be selected, while another player of at least equal merit is not given a trial? Personally, we are not inclined to clamour for the inclusion of South Africans in an English team, but we should like to see some consistent ruling on the subject.

A suggestion appeared in the *Daily Express* recently, which, if acted upon, should result in an extraordinarily good game. It was that an annual match should take place at Twickenham between England and an "overseas" fifteen, with "caps" for the "visitors." In this way recognition might be accorded in a graceful way to the really fine players from the Dominions, living for the present in the Old Country.

It appears that some of our remarks have led to a misunderstanding. In our last issue we commented upon the large number of students now doing clinical appointments, and observed that there would be in future some competition for senior dresserships, as the number of senior dressers was to be limited.

Since then we have met several men who have come to the conclusion that this can only mean one thing—a set examination. They have horrible visions of little piles of foolscap, red blotting-paper, and indifferent pens in one of the Class Rooms or the Committee Room, and an unpleasant hour or two spent staring blankly at these materials trying to formulate some sort of answer to the idiotic questions which examiners will persist in setting. We suppose that their imaginations even carry them to the point of visualising candidates walking up and down the Park before the examination, studying little sixpenny books of mnemonics.

Apparently it is the word "competitive" that rankles. Ex-service men, especially, cavil at the idea of having a written examination, in competition with younger men, whose ability for bookwork has not suffered from a lapse of three or four years, for an appointment which is so useful from the point of view of experience.

We are glad to be able to reassure them. Prospective dressers will not be called upon to undergo any special examination. Their appointment will depend upon their merits and their previous work.

The first issue of the *Guy's Directory* has met with a most gratifying reception, and those of the Gazette Committee who have been especially concerned in its production are to be congratulated on the results of their labours, which have been by no means light.

One good effect which it has had is to stimulate the interest of old Guy's men in the GAZETTE. This year there have been so far over 60 new subscribers to the GAZETTE and *Directory*, while many appreciative letters and useful criticisms have been received.

One of our correspondents points out that the names of several men who qualified within the last year or two have been entered as non-members, although they are actually life members (*i.e.* in ordinary type instead of in heavy type). Our correspondent is particularly concerned about this, in view of the recent outcry against the use of the College by non-members. And he is anxious to escape the attentions of the "sleuth-hound at the door."

May we ask, therefore, that all Life Members of the Clubs' Union whose names are not so indicated in the *Directory*, will kindly notify the Manager of the GAZETTE accordingly in order that the omission may be rectified in future issues of the *Directory*. Although every care has been taken to include, and specially indicate Life Members in the list, it is possible that in some cases the intimation as to Life Membership has not yet come to hand from official sources, and it would be well that attention should be drawn to any oversight in order that proper investigation may at once be made.

WE learn with deep regret of the death of Dr. G. C. Bright, at Cannes, on the 21st of January. Dr. Bright, who was 81 years old, was the youngest and last surviving son of our great Guy's physician, Dr. Richard Bright, the famous discoverer of Bright's disease, who, in conjunction with Dr. Addison, upheld and raised the fame of Guy's for many years.

Now that the British forces are evacuating Ireland, and with them the personnel of the military hospitals, it is very probable that considerable quantities of medical, surgical and dental material will be disposed of in the near future. Those who were so fortunate as to obtain instruments and appliances at the sale of medical stores held in England not long ago, will appreciate the value of such an opportunity to medical men.

In view of the small population in Ireland, it does not seem likely that many offers for this material will be forthcoming. If any Guy's men are likely to be in Ireland in the near future, it would probably be worth while to attend these sales, or to get into touch with the Officers Commanding the Military Hospitals.

This opportunity is, of course, particularly suitable for anyone intending to set up in practice in Ireland.

WE received, not long ago, a volume of poems by a Guy's man, Dr. Habberton Lulham. Attracted by the title—"Kettle Songs"—we spent the best part of the evening browsing (not in the Hospital sense of the word!) among its pages, before passing the book on to one of our erudite reviewers. The evening was well spent. Dr. Lulham has a happy gift of capturing humour and embodying it in verse quite naturally, without appearing forced. His views on that obscure physiological problem—Why do men sing in their baths?—are particularly well worth reading.

And not only is he a master of humour. A most human pathos, at times, creeps into his verses. Laughter, we are told, is akin to tears, and humour of the most exquisite type is often tinged with a sadder emotion.

ON the nights of February 1st, 2nd, and 3rd, the Physiological Theatre was packed with spectators at the first Residents' Theatricals held since the War. An account of the per-

formance will be published in our next issue, and we hope as well to reproduce the play itself.

In the meantime it is enough to say that the Residents provided us with a most enjoyable entertainment, and, as far as we can gather, all who saw the performance have only praise for it. Members of the staff, who were being pilloried with gusto and candour, seemed to be bearing up well, and even enjoying the process. The epilogue, an apologia addressed especially to the more prodded ones, explained very truly that it was impossible to be both funny and polite.

In addition to the Play, the Guy-Optimists contributed largely to the evening's success with their "Beer-otic" entertainment, while the Cosmopolitan Five provided music in the intervals.

Our especial thanks are due to the four ladies, the Misses Cawcutt, Price, Martin, and Fleming, who, as "co-opted" members of the troupe, enormously enhanced our enjoyment of the evening.

Events of Interest for Fortnight ending February 18th.

Feb.4.—Rugby, Guy's v. Blackheath (away). Guy's Nomads v. Park House "C" (away).

Association, Guy's v. Old Carthusians (home). Guy's "A" v. Old Grammarians (away).

Hockey, Guy's v. Christ's College, Cambridge (away). Guy's "A" v. Kenley and Purley (home).

Feb. 6.—Clinical Lecture by Mr. Mollison on "Nasal Obstruction."

*5 p.m., Prof. A. H. Todd on "Orthopædic Aspects of Rheumatoid Arthritis."

6 p.m., Boxing, Guy's v. United Insurance Boxing Club.

Feb. 8.—Clinical Lecture by Dr. Fawcett.

Rugby, Guy's "B" v. St. John's College, Battersea (home). Guy's Nomads v. R.M.A., Woolwich (away).

Association, Guy's v. London, Second Round Hospital Senior Cup at Honor Oak Park.

United Hospitals' Hare and Hounds v. South London Harriers.

*5 p.m., Prof. A. G. Timbrell Fisher on "A Research into the Pathology and Ætiology of Osteoarthritis, with observations upon the principles underlying its treatment."

Feb. 9.—Association, Guy's "A" v. London "A" at Hale End, Second Round Hospital Junior Cup.

8 p.m., Pupils' Physical Society, Paper by Mr. F. W. Widgery on "Epilepsy."

Feb. 10.—*5 p.m., Prof. C. A. Pannett on "Hydronephrosis."

7.45 p.m., Beggars' Dance at Knightsbridge Hotel.

Feb. 11.—Rugby, Guy's v. Plymouth Albion (away). Guy's "A" v. Old Alleynians "A"(away). Guy's "B" v. Old Blues "B" (home). Guy's Nomads v. Old Blues "C" (away).

Association, Guy's v. Aquarians (home), 2nd Round Private Clubs Trophy. Guy's "A" v. Old Citizens "A" (away).

Hockey, Guy's v. Bart.'s (home).

Feb. 13.—Clinical Lecture by Mr. Ormond on "Myopia." Rugby, Guy's v. Devonport Services (away).

Feb. 14.—5.30 p.m., Address by Sir William Beveridge on "Unemployment: Cure or Relief?" to University of London Union Society at the Essex Hall, Strand.

Feb. 15.—Clinical Lecture by Sir A. Fripp.

Rugby, Guy's "A" v. London School of Economics (away). Guy's "B" v. Twickenham "A" (home).

Association, Guy's v. University Coll. (home). Guy's "A" v. University College "A" (away).

United Hospitals Hare and Hounds v. Orion Harriers.

Feb. 16.—Rugby, Guy's v. Middlesex, Second Round Hospital Challenge Cup.

Feb. 17.—7.30 p.m., University of London Boat Club Dance at Australia House.

Feb. 18.—Rugby, Guy's "B" v. Worthing (away). Guy's Nomads v. Twickenham "B"(away)

Association, Guy's v. Nat. Prov. and Union Bank (away). Guy's "A" v. Nestanglo (home).

Hockey, Guy's v. Felsted School (away). Guy's "A" v. R.M.C. Sandhurst (home).

7 p.m., Dental Society's Annual Dinner at Connaught Rooms.

Publications Received.

The Medical World, Nursing Times, E. Merck's Jahresberichte, Abstracts of Bacteriology, The Hospital and Health, Middlesex Hospital Journal, New York State Journal of Medicine, Magazine of the London (R.F.H.) School of Medicine for Women, St. Mary's Hospital Gazette, London Hospital Gazette.

*Hunterian Lecture at Royal College of Surgeons.

A Paper read before the Dental Society on Thursday, 19th January, by Mr. Hooper.

Mr. Chairman and Gentlemen,

When it was suggested to me that I should speak for half an hour on the subject of "The Retention of Lower Dentures," I wondered how on earth I was to keep going for five minutes with my limited store of knowledge. And yet, on second thoughts, one realises that a satisfactory solution of this problem demands every bit of knowledge gleaned in two years in the pupils' laboratory and a very great deal more. After some weeks in the first year laboratory we succeeded in turning out a set of dentures which looked horribly mechanical and the usefulness of which we very much mistrusted. The problem in my mind was always, "How will they keep up?"

A patient was at last allotted to me, a good, long-suffering artisan, who did not very much mind the eleven plaster impressions I took of him. At last I proudly went upstairs with a beautifully polished set of dentures, but with many misgivings at heart as to whether they would stay up. Always at the back of one's mind, would they "stay up!" The good fellow eventually told Mr. Fry that they were comfortable, (God forgive him), for which I heartily blessed him, and went his way. Subsequently he wrote and told me that he was very pleased with his teeth.

I completed my six dentures, but I must admit that it was not until I had completed several more that I fully realised that the lower denture is the one which is really the seat of our troubles.

There is no doubt that at the hospital we are very often faced with the very worst possible case, that is, an edentulous case of some five years' standing, where teeth have never been worn. I suppose that in private practice it is rare to be faced with such a problem, for the average better-class patient would begin by wearing a partial lower denture almost before middle age. So we now come to the very crux of the whole problem, which is the gradual training of the patient from middle age to the wearing of a denture.

The loss of one tooth in the incisor region would justify the making of a denture in the minds of most dentists, and in the molar region the loss of a molar and premolar on either side would undoubtedly indicate a denture from a utilitarian point of view. So here we have made a start, and, as subsequent teeth are lost, the denture is either re-made or added to. When the day arrives for this patient to take to a *full edentulous lower*, his troubles will be very much minimized.

Now comes the important question—the retention of unsound teeth as anchorages for a lower denture. No single tooth left standing under these conditions is sound; each one is probably the seat of pyorrhœa alveolaris. From the surgeon's point of view such teeth most certainly ought to go, for the mouth cannot be brought to a healthy condition while they are present. From the prosthetic point of view their presence is most desirable.

No rule can be laid down. The decision must depend on each individual case. Having decided that we are going to retain teeth, which are the most serviceable for our purpose? The canines are indicated, but if it is only possible to retain one canine its diagonally opposite molar should also be saved. By examining a diagram it will be seen that these teeth are the ones which are mechanically best suited to act as anchors. At the same time canines usually seem to have greater resisting power to decay and disease than the other teeth, so that they are more often found standing. With a small canine band and the molar banded, a lower denture can be made very rigid and at the same time very light. When the time comes for these teeth to go, the patient is used to wearing a denture and has not the same difficulty with a full lower that he would have had without this previous experience.

Now let us consider the full edentulous lower plate. Firstly, what forces can we utilize to keep it down? These are:—

(a) Gravity is the principal force.

(b) Adhesion by contact.

(c) Mechanically fitting the flanges of the denture under the sloping alveolus of the mandible.

We will deal with them in order.

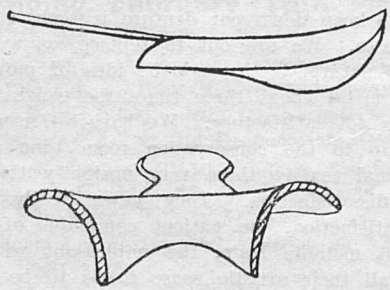
(a) *Gravity.*—The idea of depending on weight alone to keep down our denture is repugnant to all our senses. We are out to replace, as well as we can, 16 natural teeth, and the idea of putting in a bar of metal about three times the weight of these teeth is not satisfactory. We have all seen patients come up to the conservation room time and time again and remove these very unsightly things with great dissatisfaction. They never really seem to give satisfaction, the patient complains of the unpleasant metallic taste, the unpleasant weight, but above all their artistic sense seems to be offended. They imagine that everyone can see this dreadful mass of metal as they speak. As it is the patient who has to wear the thing, and as I have not seen one who has not this rooted objection, I feel that they are most unsatisfactory. With a case of this sort, where the ridge is almost undefined, I should favour springs, which are certainly not so unpopular with the patients. Weighted lowers get over certain difficulties and in some cases are undoubtedly indicated, but if this is so, let them be made of weighted

rubber or pieces of metal packed in with the rubber. In this way a great deal of the nausea of the metallic taste in the mouth is avoided.

(b) We now come to *Adhesion by Contact.* Our original idea that a large surface is advantageous can be quickly dealt with. The denture must rest on the hard, firm alveolar ridge. It is no good whatsoever having contact with soft tissue, for no retention is obtained from it, while the denture is much increased in size by this superfluous area, so that the mouth is unnecessarily crowded, and that unruly member, the tongue, has more to sport with and spit out. We must, therefore, cut our denture to cover as much as possible of the hard alveolar ridge without interfering with the lingual frenum. This may be ascertained by placing the denture in the mouth and then getting the patient to roll his tongue to the back of his mouth; if the frenum is interfered with, the denture will be lifted by it.

(c) Now if we examine a human jaw bone, it will be seen that in the molar region we have a cross section, thus :—

Therefore, if we can dovetail our denture into this, we shall mechanically lock it to the jaw. Of course, to obtain this, a good impression must be taken, and this will of necessity be a plaster one, as we are taking the impression of an under-cut. In making a lower special tray for this purpose the lingual flange should be deep, as in the diagram :—



The result is that the plaster is carried well down to A and B. A denture made with these deep flanges is brought to its position by inserting it far into the mouth, lowering the flanges over the posterior alveolar ridge, and then drawing the denture forward and lowering it over the anterior alveolar ridge. If the patient finds this comfortable, then most satisfactory retention has been obtained. If the patient complains of discomfort, then the flanges must be gradually trimmed away, and possibly removed altogether, and we must rely on other factors for retention.

The selection of teeth is of great importance. Naturally the most desirable are anatomical, and when we are dealing with a partial denture, anatomical teeth should be selected. Anatomical teeth may be employed when the patient has only just lost his natural teeth, the reason being that the alveolar ridge will be well defined and he will still retain the habit of grinding his teeth. The anatomical relation of the mandible to the maxilla is a peculiar one, and offers many problems in physics. As the resorption of the alveoli progresses, these adverse conditions become exaggerated. Therefore it follows that artificial substitutes should be inserted soon, that is, within a few weeks—two to six—after the removal of the natural teeth. As the resorption of the alveolar processes progresses, the summit of the alveolar ridge of the upper jaw recedes upward and inward, whereas the summit of the alveolar ridge of the mandible recedes downward and outward. Hence, if the artificial teeth are set in the position occupied by the natural teeth, the problems in leverage become very serious. It is apparent that if the artificial teeth could be aranged with their buccal surfaces just inside the summit of the alveolar ridge, it would be impossible to dislodge the base-plate by direct occlusion, no matter how hard or circumscribed the bolus of food; but it is not practical so to arrange the teeth; it is desirable from a mechanical point of view to approach this condition as nearly as the individual case will permit. If, after the alveoli have thoroughly receded, the upper artificial teeth are mounted upon the base-plate in their normal distance from the raphé, the work area of the lever is relatively much lengthened. Therefore, to overcome this untoward leverage, the teeth are drawn in toward the summit of the ridge. There is a limit to the inward drawing of the lingual surface of the teeth, for undue encroaching upon the domain of the tongue will ensue. That this work area may be still further shortened, the artificial teeth buccolingually are made narrower than normal. As the shortening of a radius shortens the circumference of a circle it becomes necessary to select artificial bicuspids and molars a little narrower mesiodistally than the natural teeth that they replace. This is but one of the reasons for the reduced size of the grinding teeth. Consequently in the lower denture, since the arch is narrower, the tongue is, of necessity, slightly cramped, so that the lingual surface of the denture should be reduced as much as possible. We therefore come to the conclusion that in the young and vigorous patient with a well-marked alveolar ridge we may fit large teeth with well-formed cusps, while in the old patient with greatly absorbed alveolus we are forced to select

small teeth with practically no cusps, and his masticating power will be practically but an up and down movement.

Now let us consider bands. They are a much abused method of retention, and often do much harm from being badly designed, badly constructed, or allowed to get dirty, and, worst of all, when employed as a means of disguising a failure to obtain good fit and support; but when designed, made, and cared for, are useful and harmless contrivances.

When a man has acquired a real knowledge of how efficient good fit and articulation are for the retention of partial dentures, then he may add a band, "to make sure," or to comfort a nervous patient, if he thinks fit; but a man who always "makes sure" will do a lot of unnecessary harm to good teeth and will inevitably become slack and unskilful in better methods. Bands must fit closely and no part of the clasp may stand free from the tooth, because, if it does so at the neck part, food will collect and cause decay, and at the top a bad fit will catch in the lip and tongue and cause a sore. As the spring of the gold is only slight, it follows that a clasp can only be well fitted at the bulbous part of the tooth and a little way above and below it. Only parallel-sided teeth can have deep clasps, and such teeth are rare. "Contouring" bands is a right and proper thing to do when using broad bands on bulbous teeth, but needs very exact workmanship and should be done after the plate has settled in the mouth. It is usually better practice to cut away those parts of the clasp that are opposite deep undercuts, because it is undesirable to have a band near to the gum margin, and only a moderately broad contact is needed. A very deep collar band will not prevent the tilting of a denture, because a tilting strain so resisted will loosen the tooth.

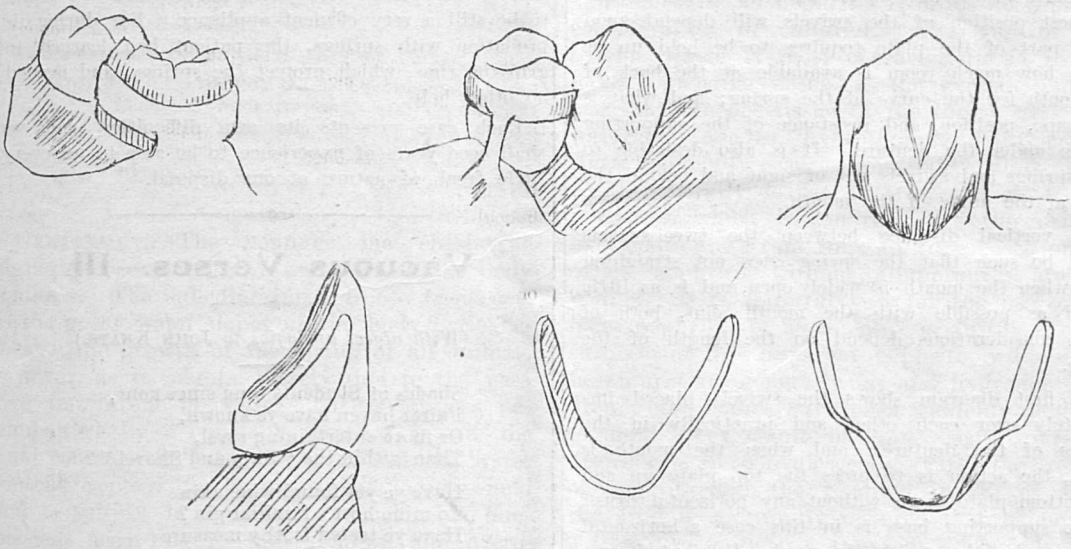
Bands should be brightly polished inside and out and all the edges bevelled off to prevent food lodging. Each band should grasp its tooth evenly on both sides and not push or pull against it. Bands act

1. by the contact giving sufficient friction to prevent its sliding up and down on the tooth;

2. by the slight undercut being gripped by the springiness of the metal; and

3. by direct resistance of the metal to lateral movement in any direction.

Another method of retention of which I have no experience whatsoever, but which sounds most attractive, is that of packing soft vulcanite into the undercuts in the case of partial dentures. I should say that this would make a most satisfactory and comfortable case, but at the same time it seems that the undercuts should be obliterated as much as possible by grinding the enamel of the teeth, so that the soft rubber does not comprise at most half the thickness of the plate. I should be most interested to hear the experiences of one who has tried this method, for the lasting qualities of the plate would not be that of one completely composed of hard vulcanite.



Now consider springs, which seem to be so greatly despised in the hospital. Springs are the only artificial means of retention that not only hold a denture in place, but also replace one that has come adrift; they are very efficient, but bulky, delicate, and make the dentures rather difficult for old pa-

tients to cleanse and insert in the mouth; also they add to the pressure of the denture on the lower jaw. Springs are not able to steady a denture that is being tilted or slid about by the force of mastication, because they only exercise ounces of pressure and the bite pounds. The teeth must still be properly set up over the ridge and away from oblique foundations.

Recent research work on the movements of the jaws has shown that the teeth move almost vertically downwards, although the anterior teeth travel a greater distance than the posterior ones. I do not believe in any one conventional place for swivels, but in every case there is one best and there are many inferior positions. The action of the spring is an attempt to straighten itself, and the force exerted acts in a straight line from the two points of contact with the dentures nearest to the bend of the spring. The best position of the swivels will depend upon which part of the plate requires to be held up or down; how much room is available at the back of the mouth for the curve of the spring; and what is the shape, position, and resistance of the supporting surface under the denture. It is also desirable to keep springs and swivels out of sight and behind the curve at the angle of the mouth.

The vertical distance between the two swivels should be such that the spring does not straighten itself when the mouth is widely open, and is as little curved as possible with the mouth shut, both of which considerations depend on the length of the spring.

The first diagram shows the swivels placed immediately over each other and practically in the centres of the dentures, and when the mouth is closed, the action is to press the top plate up and the bottom plate down without any horizontal thrust, as the supporting base is in this case a horizontal surface; also the weight is evenly distributed over the whole of each base.

But when the mouth is open, quite a different condition exists, the lower swivel is still almost below the other, yet the supporting surface in the lower denture is now no longer horizontal, and the force resolves itself in a downward and a considerable forward thrust. The upper denture is not affected.

The second diagram seems the best way to overcome this difficulty. The upper swivel and bolt are placed well forwards and the lower a little back. To make the pressure vertical when the mouth is closed, a stop has been inserted in the upper plate, the thrust with the mouth closed is thus kept vertical; this throws the pressure a little to the back of the centre.

In the upper jaw, with its very broad base and light pressure, this is not likely to produce any ill-effect, but in the lower jaw, with its narrow base posteriorly, this certainly may result in an undue pressure of the lower plate on the gum. With the mouth widely open it will be noticed that the pressure is almost vertical on the lower denture; a little thrust forward remains owing to the impossibility of placing the swivel further forward in the upper jaw for fear of showing or getting on the curved front of the denture, or in the lower further back on account of the uneven pressure.

In the upper denture there is a forward thrust, but from the shape of the mouth and the broad surface of contact this will be found of far less importance than a forward thrust on a lower plate.

Several very interesting cases are given of this sort by Mr. Douglas Gabell in his book "Prosthetic Dentistry," and well repay study. The story is told of the spring case in which after a certain amount of use, the springs broke, and the denture was found to be still a very efficient appliance. For during his probation with springs, the patient had learned to grip the rims, which protect the springs, and needed no other help.

Each case presents its own difficulties, and we shall need years of experience to be able to use every little freak of nature at our disposal.

Vacuous Verses.—III.

(*With abject apologies to* JOHN KEATS.)

Shades of Students long since gone,
Fairer haven have ye known,
Or more entertaining revel,
Than within the "Ship and Shovel"?

Have ye yet found wine akin
To mine host's familiar gin?
Have ye tasted frothy measure
Rivalling his "bitter" pleasure?
Where indeed may any sip
Choicer flavour than the "Ship?"
What forsooth could be more tasty
Than his crab and salmon pasty?
And with oyster supper rare
Truly no feast can compare.
Memories better none hath known
Than when, time and wine both flown,
He was the last to face the cold:
Who would not be a captain bold
And truly last to leave his ship
To brave a Boro' winter's nip?

Oh! Roystering song! Oh, Melody!
Oh! Lyres set to harmony,
Whose cadences exquisite rise
Without the narrow walls of Guy's

* * * * *

Shades of Students, long since gone,
Fairer haven have ye known,
Or more entertaining revel
Than within the "Ship and Shovel"?

Œdema in Childhood.

CLINICAL LECTURE BY DR. H. C. CAMERON.

1.—Œdema due to Nephritis.
2.—Cardiac Œdema.
3.—Œdema Associated with Nutritional Failure.
4.—Œdema of Alimentary Origin.
Carbohydrate Œdema.
5.—Œdema due to Lymphatic Obstruction.
Post-Erysipelatous Œdema.
6.—Œdema due to Venous Obstruction.
7.—Œdema of Nervous Origin.
Angeioneurotic Œdema.
With Acrocyanosis.
With Tetany.
8.—Congenital and Familial Œdema.
9.—Conditions resembling Œdema.
Sclerema Neonatorum.
Sclerema Adiposum.
Myxœdema.
Lymphangeioma.

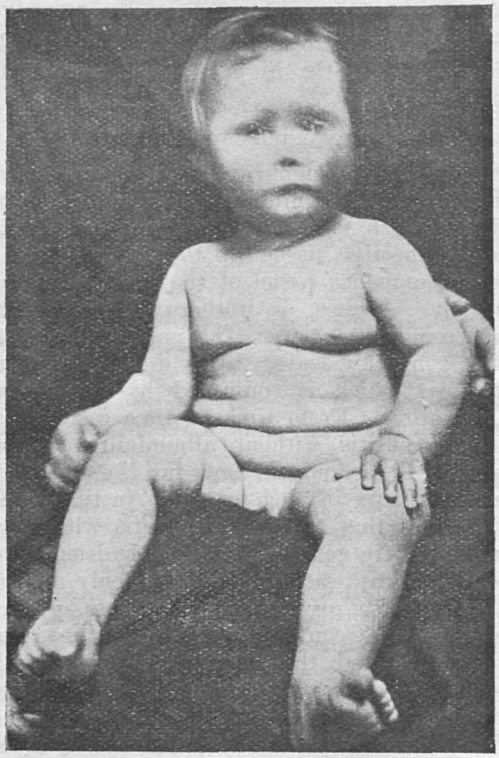
Gentlemen,—The younger the child the higher the percentage of water which the body contains. The subcutaneous adipose tissue acts as the great water depot of the body. Nevertheless, the growth of the young of all animals is never, as in plants, merely due to the passive imbibition of water, but is always accompanied by a constant increase in all the solid constituents. In young infants the water content appears to be somewhat loosely held and is subject in disease to considerable fluctuations according to the retention and excretion of salts. Thus the addition of sodium chloride, in doses of a few grams daily, to the diet is capable of causing retention of water and an increase of weight. Occasionally this retention may actually be accompanied by the appearance of œdema, even although the kidneys are not diseased and there is no albuminuria. In keeping with these observations we find œdema without albuminuria occurring more frequently than in later life. It is found in a number of nutritional disturbances, characterised by wasting or by sudden fluctuations in weight. It is especially prone to occur in infants who have been fed upon a diet in which starch and sugar preponderates to the exclusion of fats and proteins in sufficient amounts, circumstances which recall the frequency of œdema—war œdema or hunger œdema—even among the adult population in Germany and Austria since and durthe war. The high content of lymph normal to the infant's body, necessitated by the activity of its metabolic processes, is apparent in many ways, in the plump and rounded contour of its body, in the ease with which the superficial lymphatic spaces are laid open by such desquamative and ulcerative processes as occur, for example, in the so-called napkin rash, in the large size and relative prominence of the lymphatic glands—junctional nodes between the proximal and distal lymphatic trunks, —and lastly in the high lymphocytosis of the blood.

1.—Œdema due to Nephritis.

Œdema due to nephritis requires no separate consideration in children. The site of the œdema which is most characteristic is in the loose connective tissue of the eyelids and in the subcutaneous tissue of the limbs, back and scrotum. Ascites, hydrothorax, hydropericardium commonly occur. The puffy pallor of the child generally leaves little doubt as to the diagnosis which is confirmed by the urinary examination. From time to time cases of so-called nephritis without albuminuria are recorded. It is doubtful how far the use of the term nephritis in such cases is justified. The subjects of this apparent nephritis without albuminuria are generally fat and hydræmic children whose bodies have been suddenly depleted of fluid as a result of some acute pyrexial disorder. In convalescence, with the return of appetite and the renewed intake of salts, the fluid is so rapidly restored that œdema of a transitory nature is apparent. The advances of modern surgery have served to make amyloid disease, formerly so common as a late result of all forms of chronic suppuration, a complication of extreme rarity. We meet with it now only in cases of long-continued pulmonary suppuration, as, for example, in bronchiectasis or pulmonary abscess, or interlobar empyema which has ruptured into a bronchus, situations relatively inaccessible to surgical interference. In cases of this nature, however, the appearance of polyuria, albuminuria, and œdema may indicate that amyloid degeneration of the place. An associated enlargement of the spleen, and the occurrence of diarrhœa, would confirm this diagnosis. In children, cases of nephritis in which anasarca is a prominent symptom, have always a bad prognosis. When the disease has begun insidiously, the outlook is generally worse than when it follows scarlet or some other

fever. Nevertheless from time to time we meet with cases of apparently complete recovery after severe anasarca lasting more than a year.

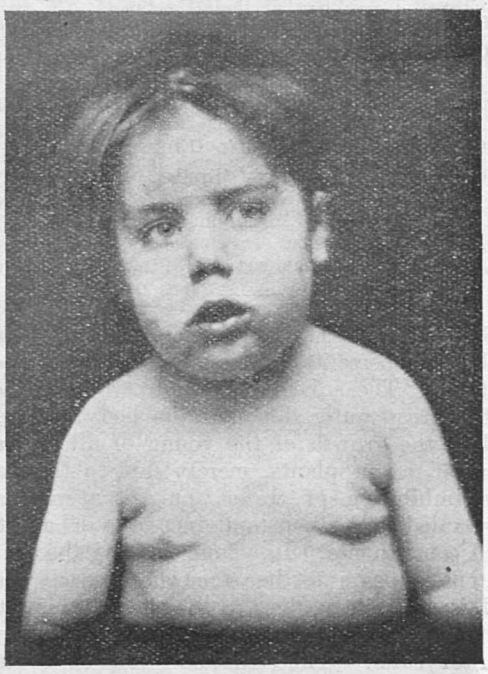
Treatment.—So long as the anasarca lasts, the child must remain in bed. A flannel sleeping suit should be worn. The skin should be encouraged to act freely. A hot bath at 105°C. should be given daily. Vapour baths, hot packs and radiant heat baths are prescribed when there



1.—Atrophy marked by a great retention of water in the subcutaneous fat. The *dorsum* of the hands and feet were cold, blue and œdematous. There had been great excess of sugar and starch in the diet with deficiency of fat. There is a patch of eczema on the left cheek.

is any tendency to urinary suppression or when the anasarca is increasing rapidly. The diet for some weeks in the early stages may consist of milk only, with an addition of one and a half ounces of sugar or extract of malt daily. In three pints of milk there are about two grams of common salt, an amount which few kidneys even when seriously diseased will fail to excrete.

In the more prolonged cases, or when the appetite fails and anæmia is a prominent symptom, a salt-free diet may be prescribed. In an ordinary mixed diet, containing perhaps ten grams of common salt, all but a very small amount, perhaps a tenth of the whole is added in the process of cooking. Without this addition the sodium chloride in a mixed diet is seldom more than can be excreted. Directions must be given to prepare all meat and vegetables without the addition of salt, and saltless scones must take the place of bread from the bakers. Limitation of the fluid taken by the mouth is seldom successful in diminishing the



2.—Another of the same. These "hydro-labile" children have a low immunity against injections of all sorts and are prone both to sudden death from acute intoxications and to inveterate catarrhal processes in all the mucous membranes. Post-mortem the condition of "status lymphaticus" is found. I believe that this is the clinical condition corresponding to that post-mortem appearance.

œdema. If the intake of extra fluid is followed by free diuresis, the patient is probably benefited by it.

The bowels must be kept open by laxatives such as jalap, or Vichy water, or Carlsbad salts. A child of five may take half a drachm of the salt daily. Diuretics are often of great service, Caffein (grs. 3), Theobromine and sodium salicylate (grs. 3), or the infusion of

digitalis (drachm 1), for a child three or four years old.

In cases which prove resistant to ordinary treatment by these means it may be right to consider the advisability of recommending the operation of splitting or stripping the capsule of the kidney as suggested by Edelbohls.

2.—Cardiac Œdema.

Œdema due to cardiac disease occurs relatively seldom in childhood. Valvular disease both congenital and acquired may be present with many other signs of circulatory embarrassment, and yet œdema may be absent or present only in trivial degree. When present, œdema is usually the result of profound pathological changes in the myocardium, sometimes combined with evidence of former pericarditis or diffuse mediastinitis.

Treatment.—The treatment of œdema of cardiac origin must be considered with the treatment of heart disease.

3.—Œdema Associated with Nutritional Failure.

Œdema of slight degree situated, as a rule, in dependent parts, is found not infrequently in marasmic children and in those whose bodies have been suddenly depleted of fluid by acute diarrhœa and vomiting. In one chronic form of malnutrition, cœliac disease, some degree of œdema is almost the rule. In chlorosis and in the more severe forms of primary anæmia we find transient œdema associated with a general puffy pallor.

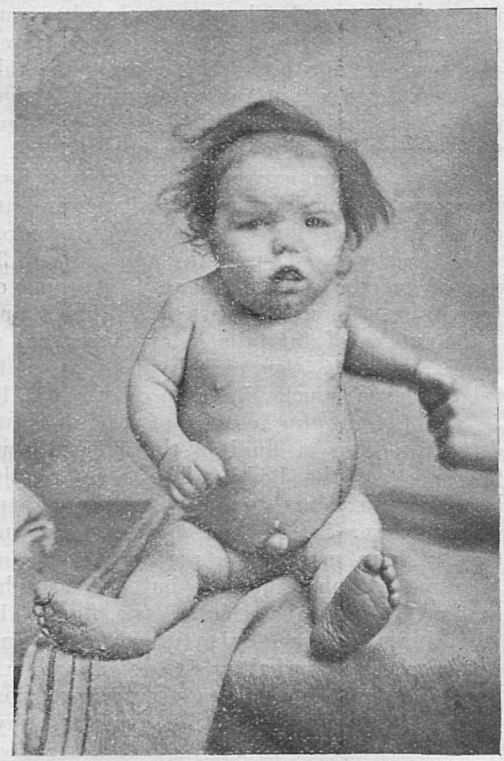
4.—Œdema of Alimentary Origin.

Among adults we recognise œdema as a prominent symptom in a group of diseases due to the lack of certain accessory food factors, Vitamines. Of these beri beri and scurvy are the best understood. In infantile scurvy, however, œdema is not a symptom which is met with. On the other hand, it is recognised that prolonged feeding upon starch, with gross deficiency of fat and protein, is capable of producing dropsy in infants. In this country it is very rare, though not unknown, to meet with a case of such one-sided feeding. On the Continent, instances seem to have been always less unusual, and since the war to have become frequent. The appearance of these hydræmic children at once recalls that which is characteristic of Bright's disease. Yet the examination of the urine excludes nephritis. The œdematous condition is combined with a striking lowering of resistance to catarrhal infections of all sorts. Furunculosis, bronchitis, nasal catarrh, enteral catarrh are all common and unduly fatal. When such acute infections occur, there may be a sudden and great loss of weight consequent upon the rapid dehydration of the body, with a sudden disappearance of the œdema. A degree of hypertonus and rigidity of the muscles is an occasional accompaniment of the œdema. Among the children of the poor of our large cities, although this œdematous form of infantile atrophy, as described, due to exclusive starch feeding is of very rare occurrence, it is not uncommon to find a dietary with a great excess of carbohydrate food and a corresponding deficiency of fat and protein. A child of two or three years of age requires about 30 grams of protein and about 30 grams of fat daily with about 120 grams of carbohydrate. In many cases it will be found that the intake of fat falls below half what is needful and that the carbohydrate rises to double or even much higher. There can be little doubt that this excess of carbohydrate leads to retention of fluid in the subcutaneous water depot of the body. The body of the child, although actual œdema is only exceptionally shown, is, in consequence, fat and watery. There may be in reality a condition of extreme atrophy present, but the atrophy is masked by the retention of the fluid. In these children also we find a great fall in immunity against catarrhal infections of all sorts and when infection occurs a very sudden loss of fluid, thus unmasking the true atrophy.

5.—Œdema due to Lymphatic Obstruction.

With severe cases of tabes mesenterica, œdema of the lower extremities is occasionally found, though its presence is to be attributed to the high degree of wasting more often than to obstruction of the abdominal lymphatic trunks. One characteristic form of œdema met with in young infants may, however, perhaps be grouped under the heading of lymphatic obstruction—that which has been described by Henoch as Post-erysipelatous Œdema. In the newly born and in older infants which are weakly, the brawny red induration characteristic of erysipelas later in life may be very transitory or even completely absent. In its place there may be a diffuse œdema which is quite pale, and which may persist in cases

which recover for a very long time. If the erysipelas affects the legs, buttocks, and scrotum, as it commonly does, the resulting œdema may give the appearances typical of the œdema of Bright's disease. The infant is, however, very ill, and there is a high and continuous fever. Often the peritoneum becomes infected presumably by way of the lymphatics and a generalised septic peritonitis may be disclosed



3.—The myxœdema of Cretinism. Note the infiltration of the *soles* of the feet and the puckered skin of the forehead.

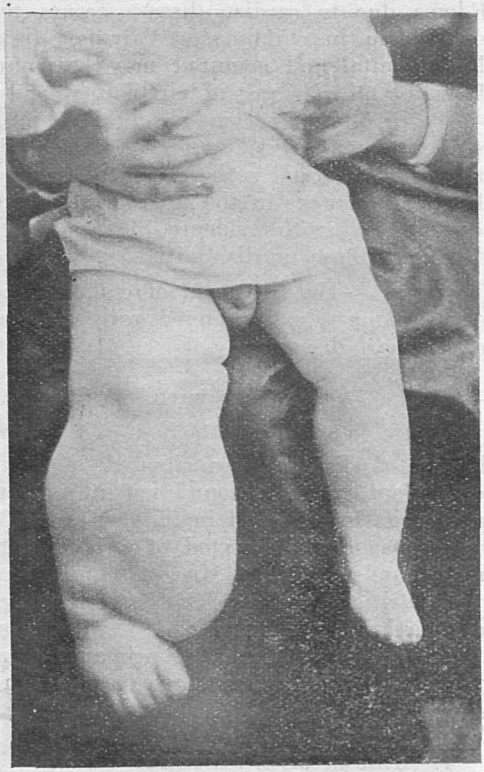
at the autopsy. In erysipelatous œdema, at least in the acute stage, cultivations of the fluid removed by acupuncture from the dropsical parts gives a growth of streptococcus longus. The œdema may persist for a considerable time after the fall of the temperature in cases which recover.

6.—Œdema due to Obstruction of Veins.

In children, as in adults, obstruction of veins may cause œdema generally in combination with cyanosis and enlargement of other veins upon the surface of the body. Pressure upon the superior or inferior vena cava or infiltration of their walls by a sarcoma is the most common cause. Gummatous mediastinitis, in cases of congenital syphilis, and Hodgkin's disease may also produce obstruction.

7.—Œdema of Nervous Origin.

Angeioneurotic Œdema. — Angeioneurotic œdema is probably more common in childhood



4.—Extensive cystic lymphangeioma of the right leg, in an infant of 10 months. The progress of this case has been very satisfactory. Two attempts at excision were made, but the swelling rapidly returned as large as ever. The child is now two years of age, the limb has grown greatly in length, but the circumference has, if anything, diminished. The swelling does not interfere in the least with walking. An X-ray examination of the leg shows great thickening of the periosteum of the tibia and fibula due presumably to the lymphatic obstruction. Wassermann negative. No other bones involved.

than at any other period of life. There is a marked family predisposition. The disease seems to be especially common among the children of Jews. Often the attacks are associated with hay fever or asthma. The disorders may occur together in the same individual, or dif-

ferent members of the same family may show different manifestations of the diathesis. The symptoms appear to be due to a vasomotor neurosis, under the influence of which the permeability of the capillary wall is suddenly increased. Children who suffer in this way are usually quick, excitable, and of a highly nervous temperament. Individual attacks may be determined by particular emotional outbreaks, fright, anger, or grief. The œdema usually occurs in circumscribed patches. The eyelids, the lips, the hands, and the fingers are common situations. Sometimes large joints like the knee joint become simultaneously distended with fluid. Giant urticaria may occur with or between the attacks. Many of the cases show dermographism. More serious, because not without risk to life, are the cases in which the œdematous swelling involves the viscera in one situation or another. Thus a serous exudate into the bowel wall may produce symptoms of intestinal obstruction, a serious exudate into the larynx may cause suffocation. I have seen cases with meningeal symptoms which were almost certainly caused by meningeal exudate. The real nature of such cases may only be apparent when considered in the light of the œdematous swellings or urticaria apparent in the skin. In most cases, however, in which visceral manifestations occur, the symptoms, although of great severity and even apparently endangering life, subside of themselves and require no operative interference. It may, perhaps, be said of them that as in asthma, with which they are closely related, the distress is very great, but the danger very slight.

In some cases the attacks follow the ingestion of certain foodstuffs and cases of idiosyncracy against egg albumen and the casein of cows' milk and many other proteins have been observed and recorded. There is clearly a close resemblance between these cases of food idiosyncracy and the anaphylactic reaction often observed after injection of allopathic protein (serum-disease).

Treatment.—When the attacks are very clearly associated with excessive emotional display and extreme nervousness, attention must be paid to the management and the personal influences which surround the child. Calcium bromide or calcium lactate (grs. 4 or 5) or liquor trinitrini (min. 1) may be tried. If the attacks appear to follow upon the ingestion of any particular food, the suspicion can be confirmed by noting the reaction of the patient's skin to solutions of the suspected protein. The test is carried out as for a Von Pircquet tuberculin test. If the test is positive an attempt may be made to desensitise by graduated injections.

Œdema with Acrocyanosis.—In certain children, usually also with a neurotic inheritance, a condition of acrocyanosis may develop. In acrocyanosis the extremities, usually the hands, less commonly the feet, are subject to attacks of cyanosis and puffy œdematous swelling. The swelling may be so great as to interfere with the flexion and mobility of the fingers, and in severe and persistent cases there may be some degree of atrophy of the small muscles of the hands. The condition appears to be a functional vasomotor neurosis. It is distinguished from erythrymelalgia, which does not occur in children, by the absence of severe pain and by the persistence of the swelling when the limb is raised.

Treatment.—Small doses of thyroid extract have been thought to do good. More often the electrical bath proves successful. The electrodes are placed at opposite ends of a foot bath and a strong current used. The hands are immersed in the middle of the bath and gradually separated until the current is as strong as can be borne.

Œdema with Tetany.—In cases of carpopedal spasm, in which the condition is severe and prolonged, an œdematous swelling is apt to appear upon the dorsum of the hand or foot.

8.—Congenital and Familial Œdema. Milroy's Œdema.

Œdema without other symptoms may be a congenital affection. There is usually, but not always, a well-marked family history of the disorder. As a rule congenital œdema involves one or both legs. The œdematous swelling diminishes with rest and increases with the dependent position. The condition lasts throughout life with a tendency to become more severe as age increases. In rarer instances the œdema involves other parts, the arms for instance, or one side of the face or cheek, with the mucous membrane of the corresponding side of the mouth.

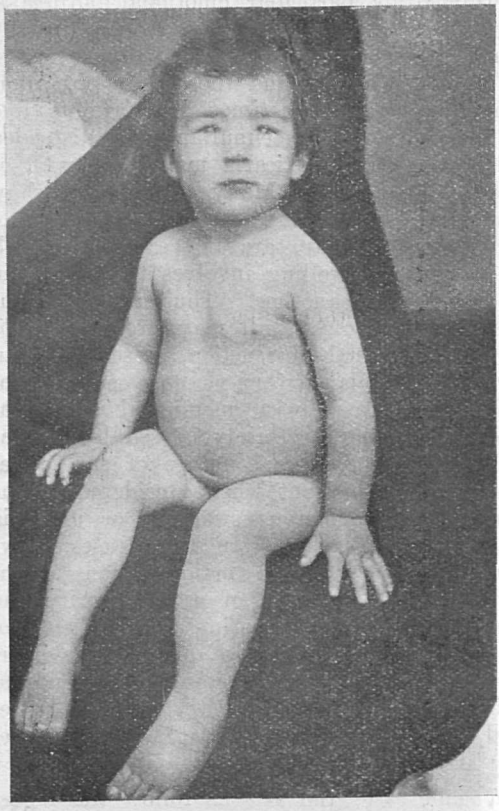
Treatment.—In such cases treatment can achieve but little. The daily increase in the swelling of the legs caused by the assumption of the upright position can be lessened by the application of well-fitting bandages.

9.—Conditions which may be Confounded with Œdema.

Sclerema Neonatorum, or *Sclerœdema*, occurs mostly in premature and feeble children. The subcutaneous tissue at birth or within a few days after birth becomes hard and swollen over a considerable area. The lower limbs and the suprapubic fat are almost always involved. The skin over the parts involved is cold and cyanosed or pale. In some cases pitting on pressure is not observed, in others a true œdema supervenes and acupuncture permits the escape of a yellowish serum. The temperature is usually subnormal, the pulse slow. The vitality of the child is very low. Coma is apt to supervene, and death takes place from cessation of respiration. The disease is one of great rarity. Its ætiology is little understood.

5.—Dermographism in an emotional, excitable infant who has suffered on several occasions from attacks of angeioneurotic œdema. An urticarial weal follows the light pressure of a pen handle.

Sclerema Adiposum is much more commonly met with. It is not altogether confined to the newly-born, and is met from time to time in older infants whose vitality is at a very low ebb, especially after severe diarrhœa. The subcutaneous fat hardens and gives to the touch the feeling as if it were frozen. The skin over it remains smooth, white and cold. There is no œdema. The inner sides of the thighs, the buttocks, the dorsum of the feet, the calves, the tip of the nose, and cheeks are common sites. When the cheeks are involved, suction may be rendered impossible. The palms of the hands ,the soles of the feet, the scrotum, and the penis always escape even when all the rest of the subcutaneous tissue of the body has become rigid as though frozen. The skin does not pit on pressure. This change in the physical condition of the subcutaneous fat is a forerunner of death. The heart beats slowly and the pulse is feeble. The respiration is shallow and sighing and may only be continued under constant stimulation.



6.—A difficult case of œdema of doubtful origin at present in the ward. The child is two years old, but weighed on admission only 17 lbs. A fall of 2 lbs. occurred within three days of placing her upon a milk diet. There is no albuminuria. The œdema is said to have begun at a month old. The child is illegitimate, and the past diet is not accurately known. It is probably a case of œdema of alimentary origin, with excess of carbohydrate food, comparable to the photographs No. 1 and No. 2.

Treatment.—The child must not be left alone or unobserved lest the respiration gradually cease. Mild stimulation of the skin by friction or pinching is generally sufficient to re-

store respiration for the time being. Hot mustard baths, brandy, oxygen, massage with olive oil, injections of camphor and of strychnine may be tried in turn. Food must be given by a nasal tube.

Myxœdema.—In athyroidism, *i.e.*, in cretinism, the most striking symptom, as a rule, is the dwarfing and the failure of the intelligence. The subcutaneous tissue is usually thickened and puffy, so that the skin, on the forehead, for example, is thrown into innumerable folds and creases, and is stiff and immobile. In some children with hypothyroidism we find considerable myxœdematous swelling of the subcutaneous tissue, without gross dwarfing or gross mental defect. As in adult myxœdema, because of the puffy swelling of face, eyelids, and extremities, a diagnosis of Bright's disease is apt to be made.

Lymphangeioma Cysticum. — Lymphangeiomata, consisting of greatly dilated lymphatic sinuses, are found most commonly in the neck. Occasionally similar swellings extend widely over a limb and may give rise to confusion with œdema of congenital origin. The swelling in lymphangeioma is, however, more limited in outline, and there is a sharper transition to the normal parts above and below.

In the Theatre.

Cholecystectomy and Choledochotomy.

The patient, a stout man, aged 53, had had an urgent operation elsewhere in August, 1921, and a long vertical incision had been made below the ninth rib cartilage. The operation was said to have been a difficult one. Cholecystostomy was performed and stones removed. The patient was a long time getting better, but he ultimately returned to work. He was re-admitted into hospital before Christmas for return of symptoms, but these abated and he was sent out without further operation. Soon afterwards he was laid up with fever. ? Influenza. He came under my care in January of this year. The present attack came on three days ago with violent pain in the right hypochondrium and slight jaundice. The gall bladder could not be felt, but there was general rigidity in the right hypochondrium. An operation was advised, but the patient would not undergo it unless it was promised that he would not be an invalid afterwards.

Operation. — Kocher incision. Very dense adhesions between the liver (lower edge) and the parieties; considerable collection of blood-stained bile below and above the right lobe of the liver. The adhesions were separated with difficulty. The gall bladder was empty and had perforated on its lower surface. Although the foramen of Winslow was defined it was impossible to palpate the common bile duct and decide if there were any stones in it, owing to the great inflammatory œdema of the sub-peritoneal tissues and of the head of the pancreas. A small stone was felt in the cystic duct and this was extracted with difficulty after opening the duct. No more could be felt. The common bile duct was opened and a large olive-headed probe was passed through it into the duodenum and up into both right and left bile ducts without difficulty and without encountering any stones. Although the patient was very ill, it was felt that he would never remain well unless the gall bladder was removed. This was therefore done with difficulty, owing to adhesions and inflammatory changes round the ducts which made it difficult to define them. When the gall bladder had been removed another small stone was found in the cystic duct. This was a great surprise. The common bile duct was drained.

This case illustrates several important points.

1. *The unsatisfactory results of cholecystostomy* as compared with cholecystectomy when the disease is limited to the gall bladder and its ducts. The patient was very disappointed in the result of his first operation, and would not return to the same place for further treatment. It may be very difficult to remove the gall bladder when it is acutely inflamed, and still more difficult to find and remove small stones in the cystic ducts. If, therefore, the symptoms recur, a secondary cholecystectomy, under more favourable conditions when the inflammation has subsided, is certainly indicated.

2. A vertical incision does not give adequate exposure for difficult gall bladder operations. The Kocher incision, extending much higher and further in, makes the operation much easier.

Carcinoma Mammæ.

The patient, a man aged 55, had for some months noticed a lump in his left breast. As it was hard, it was diagnosed as carcinoma of the breast. It was not adherent to the deep fascia and there was no obvious en-

largement of the axillary glands. A radical operation was performed; the breast, all the pectoral fascia on the left side, the lower two-thirds of the pectoralis major, nearly all the pectoralis minor and all the axillary, lymphatic glands, and fascia were removed in one block by Mr. Ogilvie.

Carcinoma of the breast in the male is fortunately rare, for it is much more serious than the similar condition in the female. The smallness of the breast and the absence of fat allows more rapid permeation of the tissues by the cancer cells, and makes it much more difficult to remove the infected tissues widely enough. It is also difficult to save enough well-nourished skin to allow a satisfactory suture of the wound. Under these circumstances the prognosis is worse.

Hydro-Nephrosis.

Due to Valve Formation at the Junction of the Renal Pelvis and Ureter.

The patient, Mrs. M., aged 66, gave a history of severe attacks of pain in the left loin, on and off for many years. Sixteen years ago she was an in-patient at the London Hospital for pain in the left flank which was thought to be due to gastric ulcer. There was no hæmatemesis. A year later she was seen by the late Dr. J. H. Bryant who found both her kidneys unduly moveable, and ordered an abdominal belt for their support. About 8 years ago she had hæmaturia for several months and albuminuria for a year afterwards. In the intervals between the attacks of colic she had an aching pain in the left flank. In December, 1921, her doctor found a large cystic swelling in the abdomen close to the pubis on the left side, and he sent her to see me, with a suggested diagnosis of growth of the colon.

When I examined her, the swelling was the size of a fœtal head, very freely moveable in the abdomen. It could be pressed back into the left loin, but not into the right loin or right iliac fossa. It was bi-lobular, the upper and left lobe being smaller and flatter than the spherical elastic lower and median portion. The left kidney could not be felt apart from this swelling. A diagnosis of left hydro-nephrosis was confidently made. The cause appeared uncertain and might be due to a small stone, an abnormal renal vessel pressing on the ureter or a kinking of the upper end of the ureter by the fall of a very moveable kidney.

X-ray examination revealed no stone, but a negative report in such a case is never conclusive, for stones small enough to enter the ureter often do not show on the X-ray plate. While the patient was in Guy's Hospital undergoing investigations, the swelling disappeared, and a very large amount of urine was passed.

Operation.—The left kidney was exposed through the usual oblique incision in the left loin. It was extraordinarily moveable and low; its cortex was fair in consistence and colour, but thin; its pelvis was empty, but greatly dilated, the ureter normal and patent throughout. The junction of the ureter and pelvis was thick and narrow and placed far above the lower pole of the pelvis, thus forming a valve which became more and more obstructive as the pelvis distended with urine. A long incision was made through the contiguous borders of the pelvis and ureters, dividing the valve. The incision was then sewn up with cat-gut after Fenger's method, thus overcoming the obstruction. Fenger's operation is like that of Finney for enlarging the pylorus. An alternative method is to make an anastomosis between the lower pole of the dilated pelvis and the ureter opposite this point. In many cases it is an advantage also to remove a large amount of the greatly dilated pelvis.

The wound healed well and rapidly without a leak of any urine, and the patient went home a fortnight later.

R. P. R.

Interesting Cases in the Wards.

Under Dr. Hurst—

Addison	2.	Tabes.
	5.	? Hodgkin's Disease.
	9.	Aortic disease.

Under Dr. Fawcett, Dr. Ryle, and Dr. Marshall—

Esther	33.	Streptococcal septicæmia. Acute nephritis.
Stephen	36.	Cerebro-spinal syphilis.
	41.	? Pernicious anæmia.

Change of Address.

Dr. A. H. Stephens, The Manor, Epsom. (Tel. Epsom 514).

Maurice Pearson, L.R.C.P., L.D.S.Eng., to c/o J. L. Trainer, L.D.S.Eng., Kimberley, S. Africa.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,— A. P. A.'s delightful letter has vividly recalled faces fast fading into oblivion. But could their ghosts revisit the scenes of their labours, they would be homeless and not find their way.

A. M. D. once took me for a walk down Mary ward, and wanted me to spot the disease from the patient's expression. To-day there is no need to see the patients; it is all known in the laboratory. Shade of the Good Physician Goodhart! I should fear to walk down Mary ward now.

Talking of "characters," there were "Remarkables" in those days. Why, the Staff and students had pegs you could hang your hats on. There was a student —a citizen of the French Revolution, who wore a red necktie; and a coming F.R.S., who read the novels of Henry James. There was a reserved man of ability, on whom the mantle of John Morley should have fallen, to lead the Liberal Party out of the wilderness; and A. P. A. (not yours, of course) with his Birrell-like love of books and wonderful animal spirits; and the magnanimous "Patch"—one of your contributors. He sent some good verses—"The Colonnade." In imagination he was a G.P., musing on the old haunts, but I deemed he peeped into Clough for two lines. "Patch" once came to me in the Smoking Room and asked me what I thought of Hardy's great novel, "Bess of the Turnip Fields."

Then there were a Cambridge student, as shy as the "Scholar Gipsy," who could have contributed weekly to the "Saturday Review" if he cared—his manuscript handwriting proved it — and Cantab.'s genial friend; one of charm from Oxford, who brought Walter Pater in his pocket for us; and one, a man of worth, whose character would have influenced the students for a generation, but he left the happy ground, via Thomas's, to see the Maple Leaf—and another from the same "sweet city," who "could not wait our passing, he is dead." I dream. Long since we have wandered all our way.

But, O youthful band of pilgrims, why were not you born in my father's dwelling—so might we talk of the old familiar faces.—Yours, etc.

RICHARD GILLBARD.

Jan. 16th, 1922.

Appointments.

Reginald Curle, M.R.C.S. (Eng.), L.R.C.P. (Lon.), Old Studley, Bournemouth, Honorary Anæsthetist, Royal Victoria and West Hants Hospital.

Notice.

Guy's Hospital Students' Christian Union.

On January 17th Dr. Fison gave an address on "Omnipotence as an Attribute of God," which was very much appreciated. About 100 students were present. Of special interest was the reference to the existence of physical and mental pain in a world the Supreme Being of which is omnipotent and infinitely merciful. Dr. Fison pointed out how it is all part of the Divine plan for the evolution of perfect souls. A number of students addressed questions to the speaker and these were all answered. Dr. Fison stressed the fact that he was not being dogmatic—merely expressing his own views for our consideration. At the same time many of us came away with clearer ideas on some of our difficulties. The meeting was closed with votes of thanks to Dr. Fison and to Dr. Campbell for taking the chair.

Other meetings will be held early in February and March. A study circle meets on alternate Thursdays at 4 p.m. in Class Room III. (next meeting February 9th). The secretary will be very pleased to get into touch with anybody interested in the Christian Union, and invites them to come to the study circle or just to put a note for him in the Front Lodge.

N. W. MACKEITH, Hon. Sec.

Reviews.

Lectures on the Surgery of the Stomach and Duodenum. By James Sherren, C.B.E., F.R.C.S. (Messrs. H. K. Lewis & Co.) Price 4s. 6d.

This small book consists of a series of lectures delivered by Mr. James Sherren to the students of the London Hospital last winter. They make very good reading and are of interest from beginning to end of the ninety-four pages. Students who are unable to hear Mr. Sherren lecture on this subject, can do no better than read this small book.

Mr. Sherren is a well-known authority on this subject, and his opinions carry great weight.

The lectures are divided into four sections:— Gastric ulcer, duodenal ulcer, pyloric stenosis, and carcinoma of the stomach. In each, he considers carefully the etiology, pathology, symptoms, diagnosis, prognosis and treatment.

Statistics are quoted from the London Hospital and elsewhere and are very instructive. The author, with many other authorities, is inclined to the view that gastric ulcer plays an important part in the etiology of carcinoma of the stomach.

Throughout the book, a very broad view is taken of the whole subject. We have no hesitation in recommending the book to all students who are interested in these conditions.

Anatomy of the Human Orbit and Accessory Organs of Vision. (Whitnall). (Messrs. Frowde. and Hodder and Stoughton.) Price 35s.

It is a pleasure to have read such an excellent book, and we must congratulate the author not only on the way in which the book has been produced, but also on the clear manner in which it has been written. We can appreciate the colossal amount of work which must have been entailed to produce the dissections, the photographs and above all the text. Not only have the more common anatomical details been fully considered, but also minute points which one rarely sees in large text books of anatomy.

The work is divided into four parts commencing with "Osteology." The chapter deals with the common anatomical conditions met with and also their abnormalities and structural type (architecture). The bony considerations of the surrounding air sinuses with their development have been fully described and the first part is brought to a close by a description of the periosteum, the development and mensuration of the orbit.

Part II. deals with the soft structures of the orbit, but not the globe of the eye. Each structure is taken in turn beginning with the eyebrows and eyelids and finishing with the lacrimal apparatus. Here the author has a large number of photographs showing minutely dissected parts of such difficult dissectible parts as the eyelids. The text ably explains these photographs, so that no doubt can be held as to what is being shown or meant. Blood vessels and nerves, and the general development of the soft parts are also considered. Part II., as in Part I., closes with a detailed description of the developmental anatomy, macroscopical and microscopical abnormalities, blood and nerve supply of the conjunctiva and lacrimal apparatus.

To our mind Part III. is the best of all the sections. Here the eyeball with its muscles, vessels and nerves are considered in detail, also the orbital fat and fascia. The author's account of the origins, insertions and actions of the various muscles being particularly well done. Perhaps even greater praise is due for the photographs and account of the nerves.

Part IV. is a chapter on the cerebral connections of the nerves and is quite short but even so keeps up the very high standard of the other parts of the work.

We might almost consider the book as epoch making—our only great regret is that the most excellent photographs were not converted into coloured plates. The printing and publishing of the book completes an excellent work.

The Surgery of the Peripheral Nerve Injuries of Warfare. By Harry Platt, M.S., F.R.C.S. (Messrs. John Wright and Sons, Ltd., Bristol.)

The surgery of the peripheral nerves is one of those subjects which have benefited by the ill wind of warfare. The accounts to be found in pre-war text books are thoroughly unsatisfactory, owing to the fact that no single writer had then had an opportunity of treating a sufficient number of these cases. This fault remains in most books of the present day, so that practitioners or men working for examinations have to rely upon one of the recent publications to supplement the deficiency. The best known are those of Benisty, Tinel, Souttar, and the Medical Research Council's Report, No. 54.

Mr. Platt's book of 45 pages contains the Hunterian lectures delivered by him before the Royal College of Surgeons this year. In spite of its brevity, it contains all that is really required by the average reader, and is in addition extremely well arranged and written in an attractive style. Condensation has been obtained by limiting the amount of space devoted to the anatomy and operative exposure of the individual nerves, illustrations taking the place of the somewhat lengthy descriptions to be found in other books. There is also no reference to treatment by splints, electricity, or to any other than operative methods. But general principles and essential details are discussed with admirable thoroughness and clearness. The illustrations and printing are excellent. What is perhaps most valuable of all is that every statement in the book is the considered judgment of a man whose experience in this field is almost unique, and we find here no recommendations of those procedures which have only theoretical or hearsay evidence to support them. On this account, and on that of its brevity and essential readableness, it is probably the best book that has appeared on the subject for the ordinary reader.

A Manual of Physics. By J. A. Crowther, Sc.D. Second Edition. (Oxford Medical Publications.) Price 16s. net.

This volume was originally published with the intention of providing first year medical students with a concise view of the subject of physics, particular attention being paid to an adequate presentation of the principles of the subject.

In the second edition various errors have been corrected and one or two slight alterations made. The minuteness of detail found in larger works has

been avoided, and yet the treatment of the subject is adequate, scientific, and not too elementary.

The book is easy to read, clearly printed, and well arranged. The definitions of units and co-efficients, and the statements of general laws are admirably expressed. In his treatment of the various subjects the author has adhered to more or less orthodox methods. No attempt is made, for instance, to rewrite the chapters on optics from the point of view of the wave theory, or those on electricity from that of the electron, although both are referred to in the text. Considerable attention is devoted to mechanics.

Representations of apparatus are purely diagrammatic. Once the student has grasped the principles of any apparatus he is expected to familiarise himself with its details in the laboratory. A valuable feature of the book is the inclusion of numerical examples to be worked out by the student.

The book may be confidently recommended as an introduction to physics. Indeed, it may be said to contain most, if not all, of the matter which a first year student is expected to know, in this subject.

Football.

RUGBY.

GUY'S v. BRISTOL.

On Saturday, January 14th, at Bristol, before 10,000 people, the Hospital team was defeated, but not disgraced, by the Bristol team. Neither side was fully represented. Bristol lacked the services of Spoors, Budd and Tucker. The last named's absence was a big loss; he, having been chosen to play against Wales next Saturday, was probably keeping fit in view of that event. Flu, or something like it, prevented Steyn and Biddle from making the journey. Graham-Davies and Duncan, nursing injuries received in the R.A.F. match, were also absentees. The ground was very heavy indeed, and no back play seemed at all possible. True there was some, but, generally speaking, conditions made the game a forward one. Guy's were excellent in the loose forward work and many a good rush took place, but evil fortune let us down, when Jacobsz failed to clear and Haysham, a home forward, gathered and found the line at his mercy. No goal resulted and no conversion followed an excellent equalising try which Sprong obtained, with some assistance on Hirschberg's part. Neser's attempt at goal was very good, but not quite successful. Just previous to this Sprong looked a certain try getter, but instead of going for the line he kicked, and a good opportunity was lost. Just on half-time Bristol scored a second try. Quick got the touch, but the home forwards carried out the movement that made the try possible. Pickles goaled and half-time followed.

Nothing was scored in the second half; both sets of forwards went all out and a very good display it was. Bristol defended well. Doherty and his men gave them plenty to do, but though many times the Guy's men were almost over, the defence held. Albertijn nearly dropped a goal. But everything was "nearly" and yet all our strivings came to nought and we had to admit defeat after a great game by 1 goal 1 try (8 points), to 1 try (3 points).

Guy's Team—J. S. Jacobsz, A. Daneel, J. G. Van Schalkwijk, P. K. Albertijn, A. Hirschberg, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, L. K. Watson, E. E. Neser, E. H. Fouraker, G. Zondagh, R. V. Cookes, F. G. Hutchinson.

GUY'S v. CAMBRIDGE UNIVERSITY.

After a night's hard frost, a thaw suddenly set in at Honor Oak Park on Wednesday, January 18th, so that by 3 o'clock the ground was playable, though still hard underneath.

Cambridge were poorly represented, about six Blues only; it was not their fault; they had only commenced term about 3 days before, and their officials had difficulty in finding out who was really in residence and who not. Smith and MacMyn among the forwards, H. B. Style at half, Douglas Cook at three-quarter, and E. R. H. Seddon, with Gardiner at full back, were the only Cambridge players who had taken part in the 'Varsity match.

Having got over an initial slide or two, the teams warmed to their work, and Guy's did some passing to such effect that Daneel, receiving from Albertijn about half way, ran strongly and, deceiving Gardiner with a clever dummy, ran in for a try. Just afterwards C. L. Steyn got another on the other wing. Neither was converted; the heavy ball was difficult enough to kick a short distance, but to boot it over the bar from a little way out required almost a superhuman kick. On the ball being restarted, it was soon dribbled back, Guy's being much better at this short kick and rush game, and then Cook, in attempting to pick up, put his knee out and had to go off, which was very bad luck. From now on Cambridge played three three-quarters. Several times Guy's heeled, the ball coming through the puddles most sedately, but Bekker was splendid, and the handling of the men behind him has seldom been equalled considering the state of ground and ball. The next try, all the same, came from the forwards, Fouraker touching down.

The second half saw several good rushes by the Light Blue forwards, though none of them brought success. Attack from the back division was not undertaken. Not so with the Hospital three-quarters. Sprong got them away on several occasions and remarkably well they played, especially Albertijn, who got two splendid tries, the dummy being disposed of so neatly that the buyers never seemed, until too late, to realise their purchase. Doherty also got a try. No conversion at all took place, and we won by 6 tries, 18 points, to nil.

The game was very sporting indeed, and the spectators thoroughly entered into the spirit of the contest. All the team played exceedingly well, and Doherty had no skirker among his speedy eight. The men behind the pack were clever indeed.

Guy's Team.—A. K. Van Niekerk, A. Daneel, P. K. Albertijn, J. G. Van Schalkwijk, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, E .E. Neser, L. K. Watson, G. Zondagh, E. H. Fouraker, F. J. Biddle, F. G. Hutchinson.

ASSOCIATION.

GUY'S v. CROYDON HIGH SCHOOL OLD BOYS.

Second Round Surrey Senior Cup (A.F.A.).

This match was played at Honor Oak Park on 21st January, the heavy state of the ground making good football very difficult. Nicholls played vice Van Geuns in the forwards.

The Hospital were early aggressive, both O'Meara and Couch having bad luck with good shots. At this period our halves were dominating the play. Both Walters and Morgan put across some good centres, but it was almost half time before Williams scored after Morgan had returned a centre from the right wing. Before the interval Lincoln equalised for Croydon with a magnificent goal, having just previously hit the upright with a 20-yards drive. This player was always a source of danger, and it was a good thing for the Hospital that he was so badly supported.

During the first fifteen minutes after the interval the play was all in favour of the Old Boys; who, however, finished weakly. O'Meara and Sennitt were conspicuous for hard tackling during this pressure. The Hospital again attacked, and Couch scored at a second attempt; from this point onwards the Old Boys were defending. Morgan scored a third goal shortly before time.

Guy's Team.—E. Hardy, C. A. Wakeford, S. E. Sennitt, O. F. Painter, D. J. P. O'Meara, J. Parry, L. Walters, W. Nicholls, L. S. Williams, D. H. Couch, and V. R. Morgan.

The forwards were troubled by the heavy ground. Walters and Morgan made ground well, but the ball could have been passed to them oftener with greater advantage. The close passing game among the inside forwards is not suited for Cup tie football.

O'Meara was excellent; the wing halves have been seen to better advantage.

Sennitt was sound in defence and placed the ball to his forwards in admirable fashion; he was well supported by Wakeford. Hardy had no chance with the shot that beat him.

SOCCER CUP TIES.

The second round of the Hospital Cup versus London has been fixed for Wednesday, Feb. 8th, at Honor Oak Park. A close, keen game is certain, as London will be out to avenge the Cup Final defeat of two years ago.

The corresponding match of the Junior Cup will be played the following day at Hale End.

The second round tie in the Private Clubs Trophy (A.F.A.) versus Aquarius will be played on Saturday, Feb. 11th, at Honor Oak Park. Aquarius are a Southern Amateur League club belonging to Honor Oak, so a great game should be forthcoming.

Pavy Gymnasium.

A Boxing Tournament will be held on Monday, February 6th, at the Rifle and Revolver Club, 2, Borer's Passage, Devonshire Square, Bishopsgate, commencing at 6 p.m. The events include a competition between Guy's Hospital Boxing Club and the United Insurance Company Boxing Club, in six different weights, two competitors in each weight. The Guy's team is as follows:—

Bantam: S. P. Meacock and M. T. Aung.
Feather: J. D. S. Thomas and C. Gross.
Light: J. S. Thomas and J. C. Mayne.
Welter: G. V. Lloyd-Williams and J. A. Currie.
Middle: H. Trafford and B. E. Hawkins.
Light-Heavy: W. H. Summerskill and N. M. Holloway.

The proceeds are to be divided between Guy's Hospital and the Insurance Companies' Charities.

Metropolitan and Southern Counties Amateur Gymnastic Association.

The M. and S.C.A.G.A. are holding their Annual Competition on Saturday, February 11th, at the Northampton Polytechnic Institute, commencing at 3 p.m. Numerous events will be competed for, both team and individual, the last event, the Amateur Championship of the Metropolitan and Southern Counties area being timed to commence at 9 p.m.

Admission is free by ticket, which may be obtained from the Hon. Sec., N. L. Lloyd.

Papers by Guy's Men.

The M. and S.C.A.G.A. are holding their Annual Bones of the Forearm following Fracture of the Radius.—*Clinical Journ.*, li., 1922, p. 32.

Cecil Worcester-Drought, M.A., M.D.Camb. Lesions of the Posterior Tibial Nerve.—*Brain,* xliv., 1921, p. 54.

Arthur S. Herbert, M.D. The Jaw-neck Syndrome: Its significance in the Rheumatic Group of Diseases. —*Lancet*, November 26th, 1921.

Guy's Hospital Dental School.

STUDENT DEMONSTRATORS OF DENTAL HISTOLOGY.

February—March, 1922.

Mr. K. G. Sharvill. Mr. H. F. Miles.
Mr' J. S. Dick,

Death.

PEDLEY.—On the 13th January, 1922, at Bridge House, Rangoon, suddenly, of heart failure, Thomas Franklin Pedley, M.D., eldest son of the late George Pedley, of Sutton, Surrey, aged 67. (By cable.) R.I.P.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

ON Monday next a General Meeting of the Clubs' Union is being held to discuss a proposal "That the Clubs' Union subscription be a compulsory payment by all students." It is, we think, essential that all who mean to attend this meeting should thoroughly consider this matter from every point of view. Its importance lies not in the mere payment of a subscription—it is fundamentally a matter of principle and affects even the constitution of the Clubs' Union.

There are, we think, two main reasons in support of such a proposal. The first is a financial one, and the second is that the acceptance of the proposal would tend to a far smoother running of the affairs of the Clubs' Union.

There seems to be a general impression that, were all students members of the Union, paying an annual subscription of three guineas (instead of five as at present), the revenue would be far greater than it is now. It is, however, just the opposite. At the present time the membership of the Clubs' Union totals 580 as opposed to approximately 300 non-members, and it is quite clear that 580 five guinea subscriptions means a greater revenue than 880 three-guinea subscriptions. In order to increase the revenue it would, therefore, be necessary to fix a compulsory subscription at a sum greater than three guineas. A suggestion has been put forward that the subscriptions, were they compulsory, should be graduated, the more active members (*e.g.*, players in the athletic teams, etc.) paying, say, five guineas, while those, who limited their activities to the use of the Club and attendances at the non-athletic societies' meetings, paid only three guineas. But the amount of work necessitated by such a procedure would, we think, outweigh its advantages.

It is undoubtedly a fact that a compulsory subscription would eliminate a fair amount of the expense and work now necessitated in the running of the Union. The subscriptions, for instance, could be collected much more readily, and it would not be necessary to employ attendants at the College and at Honor Oak Park for the purpose of preventing non-members from enjoying the privileges of membership.

There are many more instances of such economies, but we will quote only one. At present the Students' Club holds no license for the sale of excisable goods, and such is unnecessary provided these goods are sold only to members. But should such goods be sold to non-members, and this is quite likely to happen under present conditions, the Club would not

only have to invest in a license, but would also be liable to prosecution.

We have shown the advantages to be gained by a compulsory subscription, and now let us consider the other side of the question—to our mind the more important. Students enter the Hospital primarily for the purpose of receiving a medical or a dental education, and, in return, pay the requisite fees. Certain of these students subscribe, of their own accord, to the Clubs' Union. Now this institution is a Club, or, properly, an amalgamation of Clubs, subscribed to by its members for their own benefit, and has no connection whatever with either the Hospital or the Medical School. (For instance, neither the Superintendent nor the Dean, as such, has any control over members of the Union *qua* members of the Union.) Those students, therefore, and it matters not whether they be in the majority, who voluntarily join the Clubs' Union, have no right whatever to force membership upon any student who does not wish to join.

The Union has lately incurred a debt of about £4,000 (due to the building of the new stand at Honor Oak Park) and consequently the subscription was increased to five guineas. The responsibility of this rests solely with the members of the Union. Is it right, then, for these members to *compel* others to help them out of difficulties which they themselves have created? It is rather an infringement of the liberty of the individual, and as such is to be deprecated.

We have shown that a compulsory subscription would have the advantage of eliminating the work entailed in the exclusion of non-members. But is not this a necessity in the administration of every Club? It is the duty of the officials to exclude non-members, and savours rather of slackness to say, "Let's make everybody a member, and then we shall not have so much work to do in excluding non-members!"

A plea is put forward that in most public schools there is a compulsory games subscription, but we sincerely hope that we have advanced slightly beyond the age at which our actions are ordained for us by some superior being, whether schoolmaster or parent.

We have no doubt that all students should, wherever possible, join the Clubs' Union and co-operate in its administration; but there should be no infringement of individual liberty. Many students do not join owing to financial reasons, many for other reasons. It is not our part to inquire the reason why. We can explain to them the benefits derived from membership, and persuade them to join. We can not compel.

THERE are, no doubt, few who realise the precedent which is being created by the summoning of a General Meeting of the Clubs' Union. The original constitution of the Union was drawn up in 1891 by Professor Leathes, who used the constitution of the Oxford Union Society as his model. "General meetings" of the Clubs' Union were especially omitted, as it was thought that such meetings would only hinder the members of the Council in their work. To us, however, this savours rather of that type of bureaucracy with which the Northcliffe press is so often at variance. It is true that general meetings, particularly when their opinions run contrary to those of the executive, are often objects of annoyance to the latter. But, on the other hand, there are often many grievances and points of controversy with which the Clubs' Union Council never becomes acquainted owing to the lack of a general meeting.

According to the rules, members can, of course, call upon their representatives to lay these points before the Council, but in a great many cases this is not done owing to the slack attendances at Council meetings. We have

often known of meetings where only five or six members were present, and two or three of those were anxious to rush off as soon as possible. It is naturally impossible to secure efficiency under these conditions.

It would seem rather an advantage if general meetings were included in the constitution of the Clubs' Union, with the proviso of a conditional veto by the Council. Under present conditions, also, many details are held over for an unnecessary length of time owing to the long interval between the Council meetings. To avoid this, would it not be possible for the Council to appoint a permanent general purposes committee from amongst its members? This committee, owing mainly to its size, could better deal with matters as they arose, thus relieving the Council of some of its work, though, of course, it should not have power over large financial affairs.

At the same time it should be realised by everyone that membership of a committee carries with it obligations to do the work of that committee. If a man has not the time or the inclination, he can but resign or refuse to stand, and leave room for one who can do the work. No one will complain in this instance. But once elected he is naturally expected to take his share of the administration, and should not leave others to do all the work.

The University of London Union Society is at present issuing a public appeal for funds to help in the establishment of a centre for its activities. It hopes ,in the near future, to acquire possession of the Pickwick Hut, which is on the Bloomsbury site, granted by the Government to the University. The money from the appeal will be used in the necessary repairs and renovation of this building for use as Club premises.

It will, of course, vastly strengthen this appeal if the members of the Union can themselves complete the purchase of the Hut. This can be accomplished out of revenue by the Union Society, if only it has the whole-hearted support of the general body of students in the University, and it is now that it needs that support. Many students are holding back till the Union acquires premises, but it is just these students, who, by joining now, during the present session, would render certain the necessary acquisition of premises.

There is often a tendency among us to close our eyes to affairs beyond the walls of the Hospital, and to be satisfied with what we are. Narrow-minded patriotism is, however, closely akin to selfishness. We must realise that we are one of the largest colleges of the University and that, paradoxical though it may seem, more ultimate benefit will accrue to Guy's from an active participation in the affairs of the University than from a superior aloofness.

We have great hopes that many more Guy's men will join, and support the University Union, thus giving a much needed lead to the other medicals in the University. In athletics we have already proved our worth. Let us also take the lead in the social side of the university life.

The annual subscription to the University Union is one guinea, with an entrance fee of half a guinea. Membership forms and particulars may be obtained from Mr. Winston, in the Wills Library, or direct from the Hon. Secretary, at 15, Gower Street, W.C.1.

We have had great pleasure in receiving a copy of the recently issued War Memorial Number of the Guy's Hospital Reports.

This volume, the last of the old series, is a part of the Guy's War Memorial, and it places on record the part played by Guy's men and women in the Great War of 1914—1918.

It opens with an account of the War Memorial Fund; of the Memorial Arch, and of its unveiling by H.R.H. the Duke of York in July, 1921. The rest of the volume is sub-divided into three Parts.

Part I. is devoted to notices, with portraits, where available, of each of the hundred and thirty Guy's men and five Guy's women who lost their lives in the service of their country.

Part II. is a record of war services and honours, and Part III. contains papers dealing with some of the ways in which the war affected Guy's, and records some of the special experiences of, and work done by, Guy's men and women during the war.

It seems strange that the Ministry of Munitions should be in any way connected with a hospital, and yet we read with interest of the wonderful work done by Professor Lowry and his assistants in the Clinical Laboratories of the Medical School. Here were performed the experiments which revolutionised the explosives used during the latter part of the war. Sir Charters Symonds has written on the medical aspect of the Gallipoli campaign, Mr. Eason on ophthalmic practice in the Mediterranean and Egyptian Expeditionary Forces, and Dr. Hurst on "War Neuroses and Neuroses of Civil Life," amongst many other interesting and invaluable articles which space forbids us to enumerate.

This volume is indeed a true Memorial and should be the proud possession of all Guy's men. Those who have been regular subscribers to the GAZETTE for the last three or four years are entitled to a free copy, and may obtain extra copies for the sum of six shillings each. To non-subscribers the charge will be half a guinea. In our next issue we hope to state definitely the conditions under which students may obtain copies of this volume.

CONGRATULATIONS are due to the Rugby team for their recent victory over Middlesex Hospital. We wish them every success in the semi-final, and hope they will have such support from the touch line as they rightly deserve.

WE offer our heartiest congratulations also to Mr. R. F. H. Duncan on again being selected to play for England in the next International. The Association team are also to be commended on their praiseworthy defeat of the London Hospital by 4 goals to 1. On Wednesday next they meet University College Hospital in the semi-final of the Hospital Cup.

C. H. C. T.

Events of Interest for Fortnight ending Mar. 4.

Feb. 20.—Clinical Lecture by Mr. Chapple.
4.15 p.m. General Meeting of Students' Club for election of Committee.
4.30 p.m. General Meeting of Clubs' Union to consider a proposal "that the Clubs' Union subscription be a compulsory payment by every student."
Association, Guy's "A" v. London "A" at Hale End (2nd round Junior Hospital Cup).

Feb. 21.—*Sir Charles Ryall on "Cancer of the Tongue."
Rugby, Bart.'s v. St. Thomas's (2nd round Hospital Challenge Cup).

Feb. 22.—Clinical Lecture by Dr. Beddard.
7.45. p.m., Beggars' Dance at Knightsbridge Hotel.
Association, Guy's v. U.C.H. (Semi-Final Hospital Cup.)

Feb. 23.—8 p.m., Mr. G. Bernard Shaw on "The Failure of Education," at Birkbeck College Students' Union.
8 p.m., Pupils' Physical Society's Clinical Meeting

Feb. 24.—*Mr. W. Ernest Miles on "Cancer of the Rectum."

Feb. 25.—Rugby, International Match. Guy's "A" v. Downing College, Cambridge (home). Guy's "B" v. Hounslow (away).
Association, Guy's v. Old Grammarians (home) Guy's "A" v. King's College "A" (away).
Hockey, Guy's v. R.A.S.C., Aldershot (home). Guy's "A" v. Roy. Military Academy (away).

Feb. 27.—1.30 p.m., Clinical Lecture by Mr. Layton on "Incision of the Drum Head."

Feb. 28.—*Mr. R. H. Jocelyn Swan on "Hæmaturia."
Hockey, Guy's v. Balliol College, Oxford (away).

Mar. 1.—Clinical Lecture by Mr. Steward.
United Hospitals' Hare and Hounds v. Epsom College (away).
Association, Guy's v. School of Mines (away). Guy's "A" v. School of Mines "A" (home).

Mar. 2.—5.30 p.m., University of London Union Debate. Mr. G. K. Chesterton will speak in a discussion of a proposal "That this Country is governed by the Press."
Rugby, Guy's v. Bart.'s or St. Thomas's (semi-final Hospital Cup).
Hockey, United Hospitals v. Sussex County (home).
9.30 p.m., Guy's Gala Night Dance at The Frolics.

Mar. 3.—*Mr. C. E. S. Phillips on "Some Problems in Radio-Physics."

Mar. 4.—Rugby, Guy's "B" v. London Joint City Bank (away). Guy's Nomads v. Harpenden (home).
Hockey, Guy's v. Hornsey (home). Guy's "A" v. Surbiton (away).

*Clinical Lectures on the diagnosis and treatment of Cancer at the Cancer Hospital, Fulham Road, S.W. at 4.0 p.m.

The Residents' Theatricals.

It is many months ago now since the rumour first got abroad that at last the Residents' Play was to be revived. That rumour had resolved itself into solid fact soon became evident to those who spent their evenings in the College, for sounds of an unmistakable nature issued from time to time from the Residents' Room, and the windows of the Smoking Room afforded the interested spectator a vague forecast of what was to come. But in spite of these premature hints the secret was well kept and there were few who really knew what to expect when the first night, February 1st, arrived.

The programme was divided into three parts, of which the first and last were provided by a party got together by Mr. O'Meara, and called the "Guy Optimists." Sandwiched in between came the Play —"The Patient's Progress or A Day Amongst the Insultants."

The Guy Optimists gave an excellent account of themselves, and we should like to take this opportunity of congratulating Mr. O'Meara for his untiring energy in securing such a very finished performance, and of offering our thanks to the ladies who so kindly came down and added very materially, both by the charm of their presence and the excellence of their singing, to the success of the evening. In Part I. we particularly liked Miss Price's singing of "Sea Fever," though the song is certainly better suited to a male voice. The Borough Quartette—reduced to a trio by the unfortunate absence of Mr. Woodruff owing to illness—was a tremendous and instantaneous success. So good was it, in fact, that one fell to wondering how even more perfect it might have been had that inimitable comedian, Mr. Woodruff, not been prevented at the last minute from appearing.

Of the play it is not easy to write. The writer is no dramatic critic; the play had several technical deficiencies, but then one does not expect perfect technique in such a play. But we hope Mr. Braithwaite will forgive us if we suggest that the last Act was rather too long and made the whole effect a trifle top-heavy. This might have been remedied to some extent by putting some of the material of the third Act into the second. But even this might have spoiled the effect of the second Act, which was, both dramatically and histrionically, very good indeed. Act II. was, in fact, far the best thing in the play. It was really well written and admirably acted. Mr. Layton, disguised as the President of the Residents, carried the whole thing through with admirable effect, and the conclusion was inspired with true dramatic instinct. In the last Act, apart from its length, one felt the want of a concluding climax. Surely the splinter incident was the right moment for a dramatic ending! And then Mr. Elkington was kept on the stage too long with insufficient action to occupy him all the time. What really carried this Act through was the excellence of the acting. But first honours must go to Mr. Clarkson. The make ups were almost miraculous. What might otherwise have been rather a tedious Act was kept full of go and humour by the continuous entrance of the various members of the staff, all of whom were conspicuously well acted. Particularly good was Mr. O'Meara —who appeared in three different characters—and and the others were all good, but we were very impressed by Mr. Lloyd's impersonation of Mr. Fagge.

The first Act was as funny as anything in parts. Mr. Wilson, as a Borough mother, was a sight to be remembered, and contributed in no small measure to the success of this Act.

A special word of commendation is due to Mr. Turner who was really the best actor in the piece. He appeared in all three Acts and further acted—with great humour—in all three Acts. We hope his experiences will lend him an added sympathy towards his patients, whether in the Surgery, Out-Patient Department or Wards.

Having criticised—as is the duty of the critic—we would not leave the impression that the play was anything but what it was—a huge success. The audience enjoyed every word, every gesture. Now that this annual event has at last returned it is the wish of all that it has come to stay.

The entertainment concluded with the welcome reappearance of the Guy Optimists—this time in ordinary dress, with the exception of Mr. O'Meara, who had not had time to discard Dr. French's hair. Their singing was again of the high order that Part I. had led us all to expect from them and enthusiasm was general and prolonged when on the last night the President of the Residents presented each lady with a bouquet just before the conclusion of an entertainment which will linger long in the memory of all who saw it.

Change of Address.

F. W. Crook, M.R.C.S., L.R.C.P., Stafford Hotel, Chester.

T. R. Webb, M.R.C.S., L.R.C.P., Manor House, Aldridge, Staffs.

C. P. Symonds, M.B., B.Ch., 14, Portland Place, W. 1.

Geoffrey Noot, M.R.C.S., L.R.C.P., Ferndown Hill, Ferndown, Dorset.

Gordon P. Lindsay, M.C., M.B., B.S., from Lambeth Infirmary to Thaxted, Essex.

H. Q. F. Thompson, M.R.C.S., L.R.C.P., Central Native Hospital, City Deep Ltd., Box 1411, Johannesburg, South Africa.

Pupils' Physical Society.

A joint meeting of the Society with the Medical and Physical Society of St. Thomas' Hospital, was held on Thursday, January 26th, at 8.0 p.m. The patients were seen in the Surgical Theatres, and the meeting afterwards adjourned to the College Smoking Room for discussion. Mr. M. E. Shaw was in the chair.

Mr. Graham-Bonnalie showed a man who had been ill for eight years with pernicious anæmia. He had improved greatly after repeated transfusions and had been able to return to work for fifteen months. He was re-admitted with an attack of gallstones.

Mr. Dickenson showed a boy with an abdominal tumour, in whom no other signs could be found, except vomiting and slight anæmia. He thought the tumour was an enlarged liver.

Mr. Jones showed a woman with spastic paraplegia in whom all the examinations for the usual causes had been without result. She was first paralysed eight years before and was now recovering for the third time. The general opinion seemed to be that it was due to the pressure of a cyst in which fluid accumulated from time to time and gradually disappeared in the recumbent posture.

Mr .Shaw showed a woman with hysterical paraplegia of many years duration, following quickly on a fright when she was chased by a cow. Various opinions were expressed as to the best method of treatment.

Mr. Ive showed a man who had encephalitis lethargica fourteen months previously, and had since slowly developed jerking movements in his left arm with simultaneous contractions of antagonistic muscle groups.

Mr. Fawkes showed a man with gangrene of a finger of the right hand due to thromboangeitis obliterans. He had suffered from intermittent claudication in the legs for eleven years.

Mr. Forman showed a child with glands in the neck, in whom the diagnosis lay between tuberculosis and Hodgkin's disease.

Mr. Rowbotham showed an interesting case of congenital heart disease.

Mr. Hall showed a baby with irregular œdema thought to be due to excessive carbohydrate feeding.

Mr. Keast showed a girl with splenic anæmia which apparently followed an attack of tuberculous peritonitis.

Mr. Millis showed a man who had had hæmoptysis and had lumps in the thoracic wall. It was thought these were both due to secondary deposits from a primary neoplasm in some unknown situation.

Three other cases were shown, but there was unfortunately not time to discuss these; a case of enlarged liver and spleen with jaundice and nephritis—thought to be perhaps Hanot's cirrhosis—shown by Mr. Millis; a thyroid removed from a woman with exophthalmic goitre which showed tubercles; and a thyroid with the structure characteristic of Grave's disease, removed from a girl, who at the time showed no signs of hyperthyroidism, but developed these subsequently—both shown by Mr. Graham-Bonnalie.

Mr. M. E. Shaw, the President of the evening, welcomed the visitors from St. Thomas's Hospital and Mr. G. Back thanked the Physical Society for an interesting evening. Both speakers expressed the wish of the Societies that such joint meetings should be continued. More than a hundred members of the Societies were present. The meeting adjourned at 10.45 p.m.

A meeting of the Society was held on Thursday, February 9th, with Mr. A. T. Rogers in the chair. After the Minutes of the previous meeting had been read and confirmed, Mr. Widgery read his paper on "Epilepsy."

After describing very clearly the different stages of the fully developed fit and the different forms which epilepsy might take, he reviewed briefly the theories which have been put forward to explain it, starting with the old views of demoniac possession.

He developed at greater length the theory that the fits are due to local spasmodic contraction of the cerebral arterioles, and laid stress on the need for further physiological research on the question of vaso constrictor nerves to the vessels of the brain. From this point of view he compared and contrasted the fits of idiopathic epilepsy and those due to some recognisable cerebral abnormality.

The paper was followed by an interesting discussion in which the following members of the Society joined, Messrs. Maizels, Laver, Fawkes, Davis, Evans, McKeith, McKenzie, Conybeare, Campbell and others. The President moved a vote of thanks to Mr. Widgery for his paper, and the Society adjourned at 10 p.m.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

The "Schick" Reaction:

Its Principles and Practical Application.

By A. J. EAGLETON, M.D., M.R.C.P.

Introductory.

Amongst the specific fevers, commonly met with in this country, diphtheria occupies a unique position.

We know the cause of the disease; we have a proven remedy for its treatment and the means of preventing its occurrence.

And yet, each year, diphtheria exacts its toll of disease, suffering, and death. In England and Wales during the year 1920 there were 60,000 cases of diphtheria; while, if we examine the returns of the "total annual mortality of persons under sixteen years of age," we find anything but a cause for satisfaction. Since 1870 the highest mortality from diphtheria was reached in 1893; coincident with the introduction and extended use of antitoxin, the following years showed a fall, at first sudden, and then more gradual until 1900; the next five years still showed a decline; but from 1905 till now the annual mortality has been practically at the same figure.

If with all our modern improvements in methods of diagnosis and admittedly efficacious treatment we can show no better result than this, surely we should try prevention, and leave untested no measures that hold out any prospect of success.

Principles on which the Reaction is Based.

If the blood of a number of normal human beings be taken, it is found that a certain percentage of the samples examined is capable of neutralising the harmful effects of diphtheria toxin. That is to say, that certain individuals have naturally in their blood diphtheria antitoxin.

By means of delicate animal experiments the amount of this antitoxin can be accurately determined, and is found to vary from two or more units to as little as 1/100th unit* per cubic centimetre of blood; the majority of individuals who have any demonstrable antitoxin in their blood are found to possess between 1/15th and $\frac{1}{2}$ unit per c.c.

*The reader is reminded that a unit of antitoxin neutralises 100 fatal doses of toxin for the guinea pig.

Now we have abundant clinical evidence to show that a small amount of antitoxin in the blood is a sure preventative of diphtheria. In numberless instances an epidemic has been checked (in institutions, schools, etc.) by administration of quite small doses to all contacts. Protection has also been conferred on the other members of families, in which a case has occurred. In such cases we are using antitoxin derived from the blood of another species; but human antitoxin, if it could be obtained in the same concentrated form, would produce the same results.

The question then arises, "How much natural antitoxin is necessary to prevent diphtherial infection?" Schick, from numerous observations and experiments, satisfied himself that any individual who had in his blood 1/30th unit or more per c.c. was immune to diphtheria. Subsequent observations have confirmed this, but tend to show that less than this amount is sufficient. Further work on this point is in progress.

Now the methods of direct measurement of antitoxin in the blood require specialised laboratory skill and equipment; a clinical test, to be of any service must be rapid of application and reasonably simple in technique.

Such a test Schick devised, and the method of diagnosis which bears his name has not been essentially altered since his description of it in 1913.

It depends on the fact that if a small dose of diphtheria toxin be injected *into* the skin of a number of individuals, in some a specific reaction to the toxin will be produced, and in others not. This difference is due to the absence or presence of diphtherial antitoxin in the blood of the subject.

The reaction is quantitative; thus with a small dose of toxin there will be less "positives" than with a large.

Schick found that, in the case of the particular "toxin" with which he was working, a suitable dose contained 1/50th M.L.D.* He held that with this dose of toxin he could separate those individuals who had 1/30th unit or more of antitoxin per c.c. of blood from those whose blood content of antitoxin lay below this level. This, then, was the original Schick test,

*Minimal lethal dose, *i.e.*, the smallest dose producing death in a 250 gramme guinea pig in 4 days.

i.e., the injection of 1/50th M.L.D. of a certain toxin into the skin of the subject and observation of the reaction.

Evolution of the Present Test.

The early work on this test was checked throughout by direct estimation of the antitoxic content of the blood. It was invariably found that the blood of a subject with a negative Schick reaction lay above the "Schick level." Certain individuals, however, showed a reaction to the toxin although their blood contained much more than 1/30th unit of antitoxin. The test, in fact, seemed to show that they were susceptible to diphtheria, when they were in reality immune. This was spoken of as the "paradoxical reaction," and naturally at the time produced much confusion. We now speak of this as a "pseudo reaction," using the prefix correctly and not merely as a cloak for ignorance, as is too often the case; for this is a false reaction; it is not due to the toxin itself at all, but to what may be regarded at present as an unavoidable impurity.

Diphtheria toxin is produced, as we all know, by the growth on the surface of broth of a toxigenic strain of the diphtheria bacillus. The broth, with the products of bacterial activity, forms the toxin, which thus contains, besides the true "toxin," the products of autolysis of the bacilli and various chemical substances in or formed from the original medium. To some substance or substances in this broth certain individuals are susceptible, just as they are to pollen, horse serum, etc. This unknown component of "toxin" is being investigated at present, but hitherto it has been found impossible to separate it from the true diphtherial exotoxin; inasmuch as it is probably derived from autolysis of the protein of the diphtheria bacilli, it is unlikely that a toxin free from the "pseudo-reacting" substance will ever be prepared.

How, then, can we distinguish between a "positive" and a "pseudo" reaction? This can be done and in a fairly simple way. Diphtheria toxin, especially in the diluted state, is extremely sensitive to heat. The "pseudo" factor is much more stable. If we inject into the left arm of a patient the ordinary "Schick toxin" and into the right arm the same dose of toxin heated previously to 75°C., we obtain one of the following results :—

1. The left arm alone shows a reaction and the right arm none, *i.e.*, the patient has less than 1/30th unit of antitoxin and is to be regarded as susceptible to diphtheria.

2. Neither arm shows a reaction; the patient is immune.

3. Both arms show an equal reaction; this is due to the pseudo factor in the toxin; there is no reaction to the true toxin; the patient is immune.

Now there is one more possibility; a patient may be susceptible to the pseudo factor and also the true toxin, and so we may obtain—

4. Reactions on both arms, that on the left being much greater than the other. The patient has reacted to the toxin as well as to the pseudo factor; he is susceptible to diphtheria. The test, then, as used at present, consists in the injection of toxin into the skin of one arm and heated toxin ("control") into the other arm and if performed correctly and with accurately prepared reagents enables us to place an individual into one of four groups.

(a) Immune.
(b) Immune (pseudo reactor).
(c) Not immune.
(d) Not immune (pseudo reactor).

The necessity of using the "control" heated toxin is apparent; without it we cannot distinguish between group (b) and (c), although (b) is immune and (c) susceptible. The confusion of the paradoxical reaction exists no longer.

Technique of the Injection.

The following apparatus is required.—Sterile swabs and spirit; two sterile syringes (graduated in tenths of a c.c.); a number of sterile needles to fit the same. Diluted toxin and toxin "control" (heated).

Everything being ready, one syringe is filled with toxin, the other with "control." The flexor aspect of both forearms is cleaned with spirit. 0·2 c.c. of the control is injected into the skin of the right forearm; 0·2 c.c. of toxin into the skin of the left forearm. The punctures are swabbed with spirit. No dressing is applied.

Certain special precautions are necessary:—

1. The syringe and needle must fit accurately, as the injections are made under pressure. This can be determined by connecting a syringe and

needle, fitting the syringe and then plunging the needle into a cork. If the fit is accurate, very great pressure can now be applied to the plunger without the escape of any fluid from the barrel of the syringe.

2. The injection must be made into the skin itself and as superficially as possible. To achieve this result a very fine needle is used. This is inserted, bevel uppermost, into the skin until the lumen of the needle is just covered, and can be seen lying in the surpeficial layers. The injection is then made; if the needle has been inserted successfully, a good deal of resistance is encountered and a white raised wheal produced, on the surface of which are well seen the erection of the hair follicles and the pitted "peau d'orange."

Unless this effect is obtained the injection should be repeated elsewhere. It is, in fact, absolutely essential that the injection be *intra* and not *sub*cutaneous.

3. In doing a large series (*e.g.*, the members of a ward) it will be found useful to mark the syringes in some distinctive fashion, either have them of different colours or put a rubber band round one of them. Keep one syringe for toxin and one for control.

Even when only one or two tests are made it will be found very much simpler to have two syringes; if, however, only one is available, the "control" must be injected before the toxin.

4. With regard to the toxin a word is necessary. For the preparation and standardisation of this, the laboratory is responsible. It is supplied at present in a small capillary tube together with a suitable amount of diluting fluid. The reason for this is that in the diluted state the toxin is extremely susceptible to all sorts of stimuli (mechanical, chemical, and thermal) and rapidly deteriorates. The rule must be to use all the diluted toxin on the day the dilution is prepared. As mentioned in a previous paragraph the pseudo factor is much more stable; hence the "control" can be obtained diluted ready for use.

Reading the Reactions.

The patient should be inspected in a good light and both arms examined. The positive reaction is shown by a reaction on the left (toxin) arm and none on the right. The reaction consists of a raised red area, one edge of which shows the injection puncture. It is generally easily readable next morning, but may not develop until 48 or even 72 hours after the injection. At the end of 96 hours it has reacted its zenith and then fades until the skin has a puckered appearance, with sometimes a little desquamation.

A brown stain is left which persists for a variable time. In the negative response no reaction is found on either arm. The negative pseudo reaction is shown by an equal reaction on the two arms. There is a great range of intensity in these reactions. They tend to disappear early, so that, if an inspection be made 24 hours after the injection, the reaction may be called negative pseudo, whereas at 96 hours there may be no reaction visible on either arm and the result be recorded simply as negative. This early fading is not, however, a constant phenomenon.

Finally, we have the positive and pseudo, called sometimes the combined reaction. This is the most difficult of the reactions, but fortunately is rarely met with.

There must be considerable disparity between the two arms, and the diagnosis can generally only be made by careful watching and recording the readings at 24, 48, 72 and 96 hours. The earlier disappearance of the pseudo reaction may help, by exaggerating the difference between the reaction on the left and right arm. The attached diagram may serve to illustrate the readings and their interpretation :—

Toxin Left Arm.	Control Right Arm.	Reaction.	Sign.	Patient.
No reaction.	No reaction.	Negative.	−	Immune
+	+	Negative (pseudo)	− ψ	"
+	−	Positive.	+	Susceptible.
++	+	Positive and pseudo "combined"	+ ψ	"

The signs shown have proved of use in recording these reactions.

The day following the injection an accurate diagnosis can be made in about 90 per cent. of cases. (O'Brien in a recent series returned 95 per cent.) A reading on the fourth or fifth day must also be made to exclude any slowly developed positives, and the ideal procedure is a daily reading for four or five days. This is particularly helpful in the difficult positive pseudo reactions, especially if measurements of the surface area of inflamed skin be recorded.

There are two main sources of error. One of them is due to the difficulty of distinguishing between a negative pseudo and positive pseudo reaction. The positive pseudo is rare, and from direct estimation of the antitoxic content of the blood we know that the error is almost always on the side of calling the reaction positive pseudo, *i.e.*, we judge the patient to be susceptible when he is really immune. It is an "error on the right side."

The second error is avoided if fourth or fifth day readings be insisted on. It is due to the fact that a certain number of positive reactions develop late. These are missed if early readings only be taken. In all cases which give a doubtful reaction the injections should be repeated; the blood may also be taken and tested for its antitoxic content if the clinician is in touch with a laboratory where this work is done. Finally, it must be emphasised that any attempt to dispense with the "control" is doomed to failure. Some of the descriptions given either omit to mention it or do so in an uncertain way, as if its use or omission were a matter of individual preference. A very little practical experience is all that is needed to dispel this illusion.

Results obtained with the Schick Test.

The most extensive results hitherto recorded are those of Park and Zingher who have done many thousand tests on the children in New York City. The more limited series of results obtained in this country hitherto support their findings.

Only the more important points will be dealt with in this place.

Age of patient.—The greater susceptibility to diphtheria, as shown by the Schick reaction, corresponds closely with the age incidence of the disease. Thus, between the age of twelve months and three years 60 to 70 per cent. are susceptible; between three and five years 50 per cent.; and after this age there is a steady fall until we find that only 15 per cent. of persons over 20 years of age give a positive Schick reaction. Before the age of twelve months a considerable proportion of infants is protected by the mother's antitoxin, which is transferred partly through the placenta and partly by the milk. The latter fact is shown by the higher percentage of positive Schick reactions obtained in artificially reared children and has also been demonstrated by animal experiment. The pseudo reaction is rare, in early life being very uncommon in children under four years of age.

Social status appears to have an important bearing, in that children living in crowded areas show a higher percentage of negative reactions than their more fortunate brethren.

This is almost certainly due to the fact that the poorer child has more frequent opportunities of being mildly infected and so develops immunity.

Reliability of the Test.

Does a negative Schick reaction mean immunity to diphtheria? If so, how long will this immunity last? Unless the first of these questions can be answered in the affirmative, the test is of no value. We must, of course, exclude children under two years of age who may show a negative reaction due to maternal antitoxin. When this has all been excreted they will show a positive reaction. But in children of two years and over we may safely say that the test is a reliable indication of immunity.

No cases hitherto reported to the contrary can bear criticism. Either a weak toxin had been used, or the patient had already received antitoxin unknown to the doctor who performed the test. There is also the possibility of an error in diagnosis of the patient being immune to diphtheria, and having a sore throat due to a streptococcal infection.

Indirect evidence in favour of the test is also supplied by the examination of diphtheria carriers. Persistent carriers of virulent diphtheria bacilli give a negative Schick reaction, as would be expected. Carriers of a virulent bacilli may give a positive reaction.

If a subject give a negative reaction, for how long is he immune?

We can only wait and see; observations are gradually accumulating and we can only say at present that if a person over two years of age gives a negative Schick reaction, he is immune for many years, and probably for life.

Active Immunisation.

The Schick test enables us to separate the immune from the susceptible. Can the susceptible be rendered immune?

Not only is this possible but practicable, and has already been done in hundreds of cases.

A detailed description of the laboratory procedures involved in the production of the immunising agent, is of little clinical interest. Suffice it to say that it is a mixture of diphtheria toxin and antitoxin adjusted so that there is a slight excess of toxin, insufficient to be harmful to the human subject, but measurable by animal test; the preparation must be made by experts who realise the necessity of careful testing and accurate standardisation, errors in which might produce insufficient immunity and even untoward results for the patient.

The toxin antitoxin mixture (generally spoken of as T.A.T.) is injected at weekly intervals in doses of 1 c.c. Three doses are advisable. In some patients a local reaction develops at the site of inoculation; it may be at first sight rather severe, being, in the worst cases, of the same order as a well-marked reaction to typhoid vaccine. There is, however, surprisingly little constitutional disturbance, and it may be fairly stated that the question of a reaction need not deter us from using T.A.T.

Immunity develops slowly; most children react during the second month after the first injection, but within three months 95 per cent. will have become immune. In adults the process is generally slower.

The immunity is judged by the Schick reaction, and those children who still give a positive three months after injection, should receive one further dose of T.A.T.

In this country, active immunisation on a large scale is only just beginning, so that at present we cannot say for how long the acquired immunity persists. American records show that over a period of four years the immunity has lasted in more than 90 per cent. of those injected.

T.A.T. only acts as an antigen (*i.e.*, is capable of producing active immunity) when there is no antitoxin in the patient's system to disturb the toxin-antitoxin balance. Hence it is useless giving T.A.T. and a dose of antitoxin at the same time. This has been done in some cases and the clinician has argued that the ideal procedure would be to confer passive immunity at once and then let the active immunity be gradually acquired while the patient is protected.

Unfortunately this cannot be done; if T.A.T. be injected into a subject who is passively immune owing to the presence of foreign antitoxin, no active immunity results. The same rule holds in the case of infants who are passively immune owing to maternal antitoxin.

Practical Applications.

The following facts must be briefly recalled—

1. A negative Schick reaction, in children under six months and even up to two years of age, may indicate passive (maternal) immunity, and does not guarantee lasting freedom from diphtheria.

2. The majority of children from two to four years of age give positive Schick reactions.

Above this age period the percentage of susceptibles gradually falls.

3. Passive immunity by antitoxin is conferred rapidly, and rapidly passes off.

4. Active immunity by T.A.T. is slowly developed and lasts many years.

5. Active and passive immunity cannot be conferred simultaneously. In order to protect a family, school, ward, etc., against diphtheria (there being no immediate danger of the disease), we should proceed as follows :—

Immunise with T.A.T. children from six months to four years of age. In the case of persons above this age first apply the Schick test; immunise those who give a positive reaction, including, of course, positive (and pseudo). After a lapse of three months test again those who have received the course of T.A.T., and to any that still give a positive give a further dose of the mixture.

Re-test this remnant again after two or three weeks, and so on. No child should be considered immune until he has given an unequivocally negative (or $-\psi$) Schick reaction.

It is doubtful whether in this country the ideal of immunising all children will ever be obtained, although in New York, where the disease assumes more serious proportions than in England, this is already being systematically attempted.

Routine prophylaxis (by Schick test and T.A.T. where necessary) is, however, urgently called for in connection with hospitals, schools, and other institutions for children, and for the protection of the medical and nursing staffs of hospitals.

Surely it is time to exclude from diphtherial and scarlatinal wards nurses who are susceptible to diphtheria.

Turning now to the question of diphtherial epidemics—

Cases of the disease occur in a family, school, hospital, etc. Has the Schick reaction still a place? This depends on the exact circumstances. We know that, by its aid, we can find out the susceptibles within 24 hours (90 per cent. vide supra).

If at the end of this time there are any doubtful readings, we can administer antitoxin without spoiling the Schick reaction. That is to say, that the subsequent development of the reaction is unaffected.

If, then, the family, etc., can be kept under observation so that prompt treatment is available in the event of a case of diphtheria occurring, apply the Schick reaction; give antitoxin to the susceptible, who are thereby passively immunised for three to six weeks. At the end of that time active immunisation with T.A.T. can be initiated if the epidemic has declined; if not, a further dose of antitoxin may be given and so on.

If the family or school, etc., cannot be kept under satisfactory observation and the epidemic is a severe one, it is wiser to omit the Schick test and administer antitoxin to all contacts.

The physician has, in fact, to decide whether the risk of diphtheria justifies the short delay needed for the performance of the Schick reaction. The advantage of the preliminary Schick test consists not only in a saving of antitoxin administration to those that do not need it, but in the knowledge of the susceptibility of the members of the family, etc., and this may be very useful in the future.

Contacts under four years of age should be given antitoxin at once, as delay might be serious, and in any case a large percentage of such patients are susceptible.

Active immunisation with T.A.T. has no place in the presence of an acute epidemic. The reason is evident; we cannot afford to wait two or three months for the immunity to develop.

Conclusion.

This short article does not claim to deal completely with the Schick reaction; nor with the rapidly increasing bibliography of the subject. The work of my own colleagues and of many other observers has been freely drawn on, without detailed references being given. Those interested in the subject will find excellent lists of references in the "International Journal of Public Health," vol. ii., 1921, Nos. 3, 4, and 5.

For many years laboratory workers have been perfecting the weapons which to-day lie ready to our hand. The time is ripe for us to realise that with their aid diphtheria is a preventable disease; "if preventable, why not prevented?"

Papers by Guy's Men.

R. P. Rowlands, F.R.C.S. Cross-Union of the Bones of the Forearm following Fracture of the Radius.—*Clinical Journal*, li., 1922, p. 32.

F. N. Doubleday, M.R.C.S., L.R.C.P., L.D.S. Electrical Treatment in Chronic General Periodontitis.—*Brit. Dent. Journ.*, xlii., 1922, p. 100.

E. Bellingham Smith. (1) Splenomedullary Leukæmia. (2) Case of Œsophageal Stricture.—Proc. Roy. Soc. Med., xv., 1922, Sec. for the Study of Diseases of Children, p. 1.

——. Syphilitic Infantilism with Splenomegaly.—*Ibid.*, p. 3.

——. (1) Case of Cardiospasm. (2) Case of Gumma of the Liver and Sclerodermia of Face.—*Ibid.*, p. 7.

Philip Turner, M.S. Three Cases of Cirsoid Aneurysm.—*Ibid.*, Clinical Section, p. 9.

W. H. Ogilvie, M.Ch., F.R.C.S. Case of Exomphalos closed by Operation, and a Specimen of a similar Case in which Closure was impossible.—*Ibid.*, p. 10.

R. P. Rowlands, F.R.C.S. Case of Ectopia Vesicæ.—*Ibid.*, p. 11.

L. Bromley, M.Ch., F.R.C.S. Acute Abdominal Conditions.—*Practitioner*, cviii., 1922, p. 137.

T. B. Layton, D.S.O., M.S., F.R.C.S. Some points on the Problems of Throat and Ear Disease in School Children.—*Lancet*, 1922, i., p. 258.

Appointments.

A. H. Harkness, M.R.C.S., L.R.C.P.Eng., Hon. Medical Officer to the V.D. Dept., St. Peter's Hospital.

Pass List.

Conjoint Board.

FINAL EXAMINATION. JANUARY, 1922.

Medicine—

*W. R. Carling.
*F. W. Bekker.
*B. L. Laver.
A. R. N. Patel.
C. Shepherd.
F. W. Widgery.

Surgery—

*F. W. Bekker.
*B. L. Laver.
*E. H. Richards.
*F. L. Rayner.
*M. A. El Biblawi.
H. W. Taylor.
J. K. Milward.

Midwifery—

*F. W. Bekker.
B. Kessel.
F. D. Howitt.
T. E. Jones.
D. G. Sharp.
H. Richards.
L. H. B. Macleod.
C. G. Taylor.
R. Hale-White.
J. S. Hudson.
D. A. Windermere.

*Have now completed the Examination.

Royal College of Surgeons.

L.D.S.

FIRST PROFESSIONAL EXAMINATION. FEBRUARY, 1922.

Part I.—*Mechanical Dentistry.*

H. R. Allen.
W. S. Brittan.
E. J. Clother.
D. S. Hammond-Williams.
E. H. Fouraker.
R. M. Hastings.
O. J. Sidi.
T. S. L. Barritt.
F. F. Brayfield.
H. B. M. Cahill.
R. S. de Bruyn.
H. M. Doubleday.
C. H. Fox.
L. F. Handford.
J. E. Lloyd.
W. Nicholls.
E. J. C. Pearson.
J. F. Reynolds.
D. E. C. Robertson.
F. R. Taylor.
A. Tuback.
J. G. Van Schalkwijk.
D. R. P. Walker.
O. C. Warr.
L. C. Willis.
S. R. Mutch.

Part II.—*Dental Metallurgy.*

H. R. Allen.
W. P. Beresford.
E. J. Clother.
D. S. Hammond-Williams.
E. H. Fouraker.
G. M. Glennie.
N. H. Saint.
O. J. Sidi.
W. J. Barnard.
C. E. Bowen.
C. H. Archer.
P. S. Clarence.
G. W. Dibble.
T. G. Edwards.
G. W. Gathergood.
D. W. Griffith.
M. C. Hart.
N. M. Holloway.
A. F. King.
A. S. Levy.
J. Luke.
F. St. J. Powley.
G. A. Sargent.
H. P. R. Williams.
A. Perkins.
S. A. Pleasant.
C. L. Steyn.
J. P. Hartman.
S. R. Mutch.

Part III.

(a) *Anatomy and Physiology.*

(b) *Dental Anatomy and Physiology.*

*G. M. R. Van der Merve.
C. D. Farris.
H. D. Hall.
E. V. Hayes.
E. A. Lloyd.
F. A. Nicolai.
C. T. Pomeroy.
J. B. Roberts.
F. A. Sampson.
S. E. Sennitt.
*H. Wayman.
F. A. Kerrison.
S. E. Lewis.
*J. B. Maree.

*Anatomy and Physiology only.

Case of Angio-Neurotic Œdema (so called).

H.N., a well nourished lad of 22 years, presented himself because of "oppression over the chest and palpitation."

On examination the rate and rhythm of the heart was found to be normal.

There was no history of previous diseases.

On interrogation he explained that for some two or three years he had suffered from swelling of various isolated parts, such as the upper or lower lip, the face, legs, etc.

The urine was free from albumen.

As a part of the diagnosis I made a light streak with the finger nail down the skin of the man's back. At the end of five minutes a prominent red elevation was present over the streak. After a further ten minutes, the streak stood out prominently to touch and sight from the adjacent skin.

The cause of the disease is unknown. Osler states that the disease may be hereditary through many generations. In one family five generations had been affected, including twenty-two members.

Is the disease an anaphylactic phenomenon? Is it a manifestation of endocrine derangement? Or, as Quincke suggests, is it the result of inhibition of the vaso-constrictor nerves supplying the affected area?

The disease is rare—probably less than one case per million of population.

Angioneurotic œdema of the glottis has been certified as a cause of death, apart from anæsthesia. Does the disease bear any relationship to the mystic status lymphaticus?

G. O. HUME.

Publications Received.

The Prescriber, The Northerner (Magazine of Armstrong College), Nursing Times, The Serpent (Manchester University), The Antiseptic, Manchester University Medical School Gazette, University College Hospital Magazine, New Zealand Medical Journal, New Zealand Journal of Health and Hospitals, Abstracts of Bacteriology, Indian Medical Record, King's College Hospital Gazette, S.W.P.I. Magazine.

Reviews.

The Hot Springs of New Zealand. By A. S. Herbert, O.B.E., M.D. (Messrs. H. K. Lewis and Co., Ltd., London, 1921.)

The object of the author, who for many years occupied the post of Government Balneologist to the Dominion of New Zealand, is frankly to advertise the merits of that country as a health resort, especially as regards its spas. The most interesting and instructive part of the book deals with Nature's marvels, which are to be found in New Zealand in the form of geysers, mud volcanoes, and boiling springs. The descriptions are supplemented by a series of most excellent photographs. The latter will, we believe, attract more visitors to New Zealand than even the curative possibilities of the thermal spas. The interest of the reader in the thermal phenomena is further stimulated by a chapter on the theories of the origin of volcanic activity.

The greater part of the book, however, is devoted to a discussion of the various mineral springs and their effects upon disease, more particularly diseases of the joints. On the whole it would appear that the mineral waters of New Zealand are more suitable for external rather than internal medication. While there can be no doubt about the beneficial effects of spa treatment in chronic joint conditions, such as rheumatoid arthritis, we must confess that the book leaves us still somewhat sceptical as to whether the greater part of the improvement in such patients is not due rather to the physical effects of the baths, rather than to the chemical substances dissolved in the waters.

The classification of arthritis adopted by the author is not ideal. He groups all those cases which involve the temporo-mandibular joint and the joints of the cervical spine as toxic and infective, and others which do not show this "jaw-neck syndrome" as gouty or rheumatic. The importance of the elimination of focal sepsis is not insisted on as a necessary preliminary to spa treatment, nor is there any mention of orthopædic treatment.

Apart from arthritis a multitude of diseases, ranging from sciatica to renal calculus, are, according to the author, improved by the mineral springs. In many such cases it is admitted that the effects of diet and regulation of habits, rest, change of environment and suggestion play no mean part.

We fear that a perusal of the book will not induce many sufferers from severe chronic diseases such as rheumatoid arthritis to go so far afield in their search for a cure, but it may well stimulate the reader if in search of a pleasant and interesting if somewhat expensive holiday, or rest to visit the spas of New Zealand.

Guy's Hospital Reports. (Vol. 2, Fourth Series.) No. 1, January, 1922. (Messrs. Henry Frowde and Hodder and Stoughton.) Price 12s. 6d. net, or £2 2s. per vol. of 4 numbers.

Once more we are presented with an extremely interesting record of the careful and invaluable research which is ever being continued in our midst.

The opening article on Astley Cooper, by Sir Charters Symonds, shows how inestimable to the science of medicine were the determined contributions of this, perhaps the greatest of Guy's men. A firm believer in the new school of John Hunter, he based his work not only on the theories and teachings of others, but also on his own personal experiments, and carefully impressed his excellent methods on all to whom he himself taught.

This article also gives an interesting impression of the conditions in the medical world at the time.

"Splenic anæmia" is shown, by A. A. Osman, to be a clinical syndrome, probably the result of a chronic infection situated in the spleen itself. A primary focus of infection is found in some cases with a resultant cure on removal. These statements are substantiated by a well arranged list of case histories and statistics.

In "Summer Diarrhœa" heat may, according to Dr. Cameron, be prejudicial in two ways, firstly, by encouraging the contamination of the milk supply, and secondly, by its physical effect on the child itself. For the adequate treatment of this ailment it is not sufficient to concentrate only on one or the other, but attention must be paid to both these points.

A very useful article is contributed by Dr. Barber on "Two cases of adolescent knock-knee."

"Vicious circle," or regurgitant vomiting after gastro-jejunostomy, is shown by Mr. Rowlands to be due to variable degrees of obstruction at, or near, the anastomosis, with a resultant regurgitation into the stomach of excessive quantities of bile, pancreatic juice and food. The symptoms and diagnosis of the condition are given and stress is laid on careful attention to every detail of the original operation. The method of relief most strongly advocated is an entero-anastomosis with closure of the proximal limb of the jejunal loop.

The volume is concluded with an excellent article on the "Heteromorphoses of the human body," by Dr. Nicholson, who has classified these anomalies according to their inception. Great importance is attached to the influence of environment and external stimuli on the differentiation of tissues during their growth and development. It is wrong to assume an inherent vicious predisposition of the cells. Where the environment is normal differentiation will inevitably be so too; where cells are exposed to abnormal influences they will as inevitably undergo differentiation in an abnormal direction. It is not

too much to hope that further investigation of this subject may furnish a clue to the growth and development of tumours, and we can sincerely recommend this interesting article not only to clinical students and practitioners, but also to those pre-clinical students who are engaged in the study of embryology.

The value of these articles will well repay a close study of this number of the "Reports," and we congratulate the publishers especially on the excellently clear and concise illustrations which accompany Dr. Nicholson's article.

Kettle Songs. By Habberton Lulham. (Messrs. Combridges, Hove.) Price 3s. 6d.

Mr. Lulham is one of our Sussex poets who is worthy of some consideration. He has a distinct style of his own. He has also mastered the difficult art of giving satisfactory expression to moods as fleeting as April rain.

In "Kettle Songs" he has given us a selection of poems whose very charm is their variability. His fancy strays like a butterfly from one topic to another, but it never loses sight of the humorous. There is a hidden smile behind his graver moods, although it is rather a wistful one at times.

His humour has a wideness that admits of many shades, but he is more in his element in the finer than in the more obvious. In a poem like "Cuckoo," half ironical and wholly delicious, he is at his best. There are one or two in which the effect is more sought after and which lack his usual spontaneity. But he makes up for this in an irresponsible burst of gaiety like "A Triple Alliance." "Ichabod" deserves a special mention to itself, with its neatness of turn and air of gentle malice.

Here and there in his lyrical pieces there are touches that recall Mr. W. H. Davies. As, for example, in the two charming bird songs, "A Mark Tapley" and "Scutty."

In a more fanciful vein he is as delightful. His lines on "The Strawberry Cow" should be quoted in full if only for their originality of thought.

One of the characteristics of Mr. Lulham is that he chooses his words with an instinctive art, that just saves him at times from verging on the commonplace. His verse is careful, and has now and then flashes of real beauty. "Those soft small feet drawn up and bare," from La Belle au Bois Dormant, is very tenderly expressed, and the lines ". . . flocks of feasting goldfinches glint in the air," have an unmistakable beauty of colouring.

Although a Sussex poet there is not much mention of Sussex, except in "High Hopes," which breathes of the Downs. There are one or two dialect poems, however, of which the best is "The Constant Swain."

Mr. Lulham has a philosophy behind his laughter which peeps out unexpectedly at times, and gives an added value to verses that have already much to recommend them. All who can, should take their first opportunity of reading these poems. They are well worth the trouble.

Specialities.

Messrs. THE BERNA MILK CO., Thoune, Switzerland.

Sole Importer, J. E. Garratt, 96, Southwark Street, S.E.

The Berna Milk Company has spared no pains to show, by a series of analyses extending over a period of nearly two years, that the Condensed Milk of this company, as compared with every other brand, has the highest nutritive value, *i.e.*, is richest in cream (butter-fat).

Condensed Milk, originally made in Switzerland, is now manufactured in many other countries, although the importance of this fact has not perhaps until now been generally understood, or if so, not thoroughly appreciated.

It is maintained that the pastures of the Swiss valleys and mountain sides of the Bernese Oberland, where "Berna" Milk is made, produce the finest milk in the world, and as the brand supplied by this Company is the only Condensed Milk obtained entirely from that section of Switzerland, it claims its superiority over all other makes.

This Company has a model milk condensery at Thoune, where, under the strictest hygienic conditions and supervision in every stage of its preparation, "Berna" is produced.

Samples and full particulars will be supplied to medical men on application to London address above.

THEODORE HAMBLIN, Ltd., Dispensing Opticians,

5, Wigmore Street, Cavendish Square, W.1.

By close attention to the requirements of Ophthalmic Surgeons, both in the matter of the dispensing of prescriptions and in the supply of ophthalmic instruments, Messrs. Hamblin have established themselves as the leading West End Opticians.

In their newly erected factory in Aybrook Street, W.1. they manufacture their own lenses, spectacle-frames, and instruments, amongst which may be mentioned a model Morton electric Ophthalmoscope, which deserves the attention of those interested.

In their handsomely furnished fitting rooms, a great point is made of accurately carrying out instructions, not only as regards the lenses, but also in the correct fitting of spectacle-frames, without which the best lenses are valueless.

Messrs. Hamblin have many branch establishments in Provincial towns, and have recently opened a Hospital Department at 50, New Cavendish St., W.

Ophthalmic Surgeons are assured of their best services at all times.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Industrial Welfare Society.

Dear Sir,

The Medical Committee of the Industrial Welfare Society, of which I am Chairman, has been requested by many Firms to suggest a suitable form for the use of Medical Officers when making their examination of Employees. As I write about 3,000 medical reports every year I realise that the carrying out of this suggestion is a more responsible and important task than at first sight appears.

I am endeavouring to secure the kind co-operation of Managers and Medical Officers in this matter, but since (as I saw it stated a few days ago) there are something like 250,000 factories in the country, it is impossible to secure the fullest possible information without the assistance of the Press.

If firms which have had experience in medical work will send me any forms or suggestions they will be extremely valuable to my Committee in preparing the most suitable forms for various conditions. A copy of notes based upon my own experience in industrial medical work will be sent to any who are interested, and I shall value comments and criticisms upon them.

Yours faithfully,
D. A. COLES, M.D.,
Chairman of the Medical Committee of the Industrial Welfare Society.

51, Palace Street,
Westminster, S.W.1.
February 8th, 1922.

LEPLAY HOUSE.

Among events of outstanding interest in the Leplay House Winter Programme, is a lecture organised by the Sociological Society, at which Mr. George Russell ("A.E.") will speak on "Ireland, Past and Future," on Tuesday, February 21st, at 8.15 p.m., at the rooms of the Royal Society, Burlington House. Lord Henry Cavendish Bentinck will be in the Chair. This is instead of the meeting in November last, at which Mr. Russell would have spoken on "The Cause of Conflict Between Great Britain and Ireland," had he not been unavoidably prevented by the illness of a colleague.

Other interesting announcements in the Programme are a lecture by Mr. W. T. Constable (lecturer at the Wallace Collection) on "Art and Society," at Leplay House, on March 14th, arranged by the Sociological Society, and a series of meetings organised by the Civic Education League, of which the next will be a paper given by Miss Margaret E. Tatton, on "Art in Relation to Education," on Thursday, March 2nd, at 8.15 p.m.

On Thursday, April 6th, at 8.15 p.m., Miss H. M. Barker, B.Sc., will give a paper on "Occupational Education." These papers will be followed by discussion and non-members can be admitted on application to the Secretary at Leplay House, 65, Belgrave Road, S.W.1.

Easter Visit to Holland.

Last year the Civic Education League organised a very interesting Easter visit to Belgium for the purpose of Civic Study. This year a similar visit to Holland is being arranged. Anyone interested in Civic studies may join the party and early application to Miss Margaret Tatton, Secretary, Civic Education League, Leplay House, 65, Belgrave Road, S.W.1., should be made.

It is proposed to leave London on Thursday, 13th April, and to return on Thursday, 27th April. Visits will be paid to Rotterdam, The Hague, Leyden, Haarlem, Amsterdam, Utrecht, and possibly Dordrecht and Middleburg. There will also be opportunities of seeing rural life in several parts of the country.

Following out the ideas for which Leplay House stands, attention will be given throughout to the chief social and economic institutions of the country. Members of the party will have special facilities for first-hand contact with the work and personnel of those institutions. Education and Municipal, Commercial and Political life will be studied in this manner. Special attention will be given to the world famous Horticulture, and Holland being one of the greatest Art centres in Europe, special attention will be given to the galleries and museums. Architecture, including present day housing developments will be studied. Mr. Alexander Farquharson, M.A., will be in charge of the Educational arrangements throughout.

Clubs' Union.

A General Meeting of the Clubs' Union will be held in the Physiological Theatre at 4.30 p.m. on Monday, February 20th, to consider the question of making the Clubs' Union Subscription compulsory to all students.

It is requested that as many Members as possible attend this Meeting.

Non-Members are invited to come and give their opinions.

Guy's Gala Night Dance.

A Dance will be held on Thursday, March 2nd, at the "Frolics," Warwick Street, Regent Street. The general scheme of the decorations, refreshments, etc., will be in Guy's colours—in fact it will be a regular gala night. It is hoped that members of the D'Oyle Carte Opera Co., will attend and give a cabaret performance, and, of course, the inimitable Cosmopolitan Five will all be there.

Dancing is from 9.30 to 3, and the price of tickets is £1 double, or 12s. 6d. gentlemen, and 7s. 6d. ladies.

As 50 per cent of the proceeds will be handed over to the Guy's Hospital Appeal Fund it is hoped that as many as possible will attend, and, while enjoying themselves, help to speed on the good cause of the Hospital.

Tickets may be obtained from:—Messrs. W. D. Doherty, R. F. H. Duncan, P. O'Meara, H. G. R. Canning, J. E. H. Duckworth, J. R. A. Moore, and C. H. Edney.

Football.

RUGBY.

GUY'S "A" v. ROSSLYN PARK PUBLIC SCHOOLS.

Played at the Hospital ground, Honor Oak Park, Saturday, January 14th. The Boys turned up short. Garland of Guy's therefore played for the Schools and made the number 14, Guy's playing a like number. The Schools won by the margin of 1 goal 5 tries to 1 goal 2 tries, 20 points to 11 points. They were victorious because of their better condition, and owing to the slackness of the Hospital forwards. Cup ties are coming on and it is hoped men will soon show better evidence of training. L. B. Helder was much the best. He and H. G. Close worked hard; occasionally G. G. T. Tregarthen came into the picture. Behind, Meacock and Finnemore were excellent, also H. K. Williams. Had this last player been given the ball more, a different story might easily have to be told. Van Niekerk was invariably tackled in possession. Sem is scarcely a centre, Thomas ran with great pluck and Daneel was patchy. The last named should have stopped at least two of the tries. During the first half, Griffiths (Oundle), scored a couple of good tries, and Taylor (Epsom) on the other wing got a try. The last named is full of "ginger" and goes for the line like a steam engine. Griffiths is of lighter build, but runs particularly well. Wilkinson (Wellington) kicked well for all the goals, but not quite accurately. Williams got one unconverted try for Guy's before ends were changed.

Guy's went ahead on resuming, Williams and Roper scoring, and Tregarthen converting once. But the Public Schools soon took charge of the situation. Taylor got two more tries, running with the greatest spirit. It was a treat to see him. Wilson (Glenalmond) also scored, and Stack (Whitgift) converted once. Wilkinson (Wellington), captained the Schools and his forward play was excellent. The game was most enjoyable, the Guy's men entering fully into the spirit of it—they can afford, however, to shed some flesh, and then doubtless will be able to last as well as any opponent old or young.

Guy's Team.—S. Daneel, H. K. Williams, A. K. Van Niekerk, J. Sem, J. D. S. Thomas, S. P. Meacock, H. Finnemore, L. B. Helder, N. G. Holloway, H. G. Close, C. F. Morrison, G. G. T. Tregarthen, W. F. Roper, V. R. Estment.

GUY'S v. GLOUCESTER.

This match had been much looked forward to by Guy's supporters. It was hoped that the defeat we received earlier in the season would be avenged; it was also hoped that the Hospital XV. would give the gentleman who writes so acidly about us in the local Gloucester paper something to write about; and they did. On Saturday, January 28th, the crowd at Honor Oak Park was almost as big as that which, on a lovely autumn day in 1920, saw Guy's v. Blackheath. Gloucester were not at full strength. Dix at half, Kerwood full back, and Ayliffe a forward, were not able to play. Graham-Davies, Duncan and Zondagh were absent from Guy's so nothing can be made out of the fact that either side was not exactly up to standard.

The start was rather alarming, five minutes had barely elapsed and people scarcely realised that the looked for struggle had commenced, when Millington charged down a kick, by Van Niekerk I think, and scored a try which he himself goaled very finely. One almost envied the lack of excitement the players appeared to feel at this early reverse. Some few ardent Guy's supporters felt a rise of temperature. But they soon became normal when Guy's rapidly settled down and the forwards got the ball more often from the scrums. The passing of the three's became more perfect as the handling proceeded and at length, from a mistake by Voyce, Bekker got his threes away and Steyn, the last to receive, went over by the corner flag. No goal resulted. Hall, a lusty forward, played among the Gloucester backs, but eight men from Gloucester couldn't hold our pack this afternoon, so that Hall's withdrawal made our task easier still. Daneel now registered a try from a penalty. Then passing recommenced, Albertijn thought it better to kick ahead of the opposing threes, and a most judicious kick it was too, Steyn dashed up, secured the ball on the bounce, and was away with all the running of an even-timer. He scored splendidly. Never has Steyn run with such "ginger." May it long continue!

After half-time is was good to see Daneel get a try. Sprong kicked and Albertijn handled before Daneel made his final effort. Do not think Gloucester were asleep, their forwards were doing all they could, Voyce, Smart and Roderick. The Guy's eight were more alert, down quicker and shoving with any amount of leg power. They had the Gloucester pack fairly set, both in the tight and the loose as well. Bekker was really splendid at the base. All the outside were in tip top form, Albertijn especially being magnificent. His display reached a very high standard. No one at Honor Oak Park saw in Albertijn's display anything but very High Class Football, International form in very truth. All the pack were very good indeed. I hesitate to mention one in particular. Doherty and his seven played as one man. Our next success was via the forwards, then Becker, Albertijn, Van Schalkwijk and Steyn. This time Van Schalkwijk

goaled, Steyn had got to the posts with his try. Our full back was quite useful, but he had not much to try him. Now came a dazzling run by Albertijn. He really had a great day out, swerving and selling dummies in his own particularly successful fashion. He at length punted, and the ball appeared to bounce from a Gloucester man, close by the line, where Van Schalkwijk came up at great speed and touched for a try. The try, easily placed for goaling, was not converted, and a great match ended. Guy's 1 goal 1 penalty goal and 4 tries (20 points), to 1 goal (5 points).

The team had not half so easy a game as this report apparently makes out, but they overcame any opposition with skill and pace, in all departments of the game. May one give a special word to that Sportsman, J. G. Van Schalkwijk. Very seedy on Thursday, somewhat better on Friday, not at concert pitch on Saturday, he still decided to play. He played splendidly and one hopes his sporting spirit has not made his cold, or whatever it was, any worse.

Guy's Team—A. K. Van Niekerk, A. Daneel, P. K. Albertijn, J. S. Van Schalkwijk, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, E. H. Fouraker, L. K. Watson, E. E. Neser, F. J. Biddle, P. G. Harvey, F. G. Hutchinson.

GUY'S v. BLACKHEATH.

A great pity the day was so bad for this match at Blackheath, on February 4th. All London Rugby enthusiasts had looked forward to the encounter and many stayed away, afraid to brave the blizzard. Those who did turn up, and there were some 3,000, were well repaid. It was a great game, played under conditions trying in the extreme. A slippery turf—and little turf at that—sleet, snow and rain, and perishingly cold. Much of the play was with the forwards, but the reason for this was not the weather, it was the fact that Blackheath were heavier in the pack and they got the ball three times out of four from the scrums. Our fellows were overweighted forward. Perhaps our hooking was at fault? Early on, Albertijn had a shot from a penalty and then Neser had a shot from a long way out, both fell short. Some passing was indulged in and we got a foothold in the home "25." The ball came out on the Blackheath side and was booted away to Steyn, who cleared an opening and cleverly dropped a goal. Much of the following exchanges consisted of forward rushes, but the forwards of Guy's were the better at this game. Taylor, Harvey, Fouraker ever in the van. At last play centred round our 25 yard line, and we were penalised. Cumberlege had a shot at goal, but it was wide, though a good attempt. Albertijn fielded, but was tackled almost at once. However, the ball was got away, Neser doing splendid work. Just on half-time a Blackheath forward hurt his knee and had to temporarily retire. Some fine defensive kicking by Albertijn and Van Schalkwijk marked the end of the first 35 minutes.

Resuming, the Blackheath team had the snow at their backs. Brown, Blakiston, Marsden-Jones, all Internationals, doing yeoman work in the Heathen's pack, though their best forward was one Haslett. Bekker and Young had a great duel in their respective positions, the base of the scrum. I do not agree that Young got the better of Bekker. Honours were easy, but shaded in Young's direction, because his pack pushed our men and got the ball more frequently. Wilson, playing on the right wing of Blackheath, made a couple of dashes, but our defence held. Van Niekerk playing very steadily in the last defensive position. Then L. G. Brown came along, but these attacks were repulsed. A scrum formed in our "25," just inside the line, brought misfortune. A free kick for offside being well taken by Cumberlege and the penalty goal he scored made us but one point to the good. Steyn, who has never played better, saved us two or three times by going to Van Niekerk's assistance, and a little later the same player got clean away from a pass by Van Schalkwijk, but the Referee brought him back and ordered a scrum. The decision was a little difficult to follow. Excellent the side played the last 15 minutes. The forwards and backs playing like a real team. The men in front scrummed hard, the men behind attacked at all points and found touch neatly when attack was baulked. Sprong ran through beautifully, his pass to Steyn was splendid, but Cumberlege was in the way. Albertijn sent a high pass to Steyn, purposely high, but Steyn and Cumberlege both went for it and a knock on resulted. Neser, Sprong and Fouraker all went for the line, and within 5 minutes from the end the ball was handled right along the threequarters, for Steyn to neatly place behind for a try. Neser's kick was good, but not quite successful and soon after a most interesting game ended in Guy's favour by 1 dropped goal 1 try (7 points), to 1 penalty goal (3 points).

Guy's Team.—A. K. Van Niekerk, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, A. Daneel, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, R. F. H. Duncan, E. H. Fouraker, L. K. Watson, P. G. Harvey, E. E. Neser, F. J. Biddle.

ASSOCIATION.

GUY'S v. OLD WESTMINSTERS.

This match was played at Honor Oak Park on Saturday, the 28th January. The ground was in a very bad condition and consequently the standard of football was not very high. Guy's started off with much dash, and an excellent movement amongst the inside forwards nearly resulted in a goal. Our opponents then carried the play up to our goal and scored, after 12 minutes. Couch soon equalised and Guy's began to press. Walters contributed a second goal, and after a few minutes Williams added a third. Shortly before the interval Couch registered the fourth goal. After half-time play became more even, and several nice movements saw the Old

Westminsters draw dangerously near our goal. Hardy brought off some excellent saves, and it is largely due to his display that the margin of our win was so large. No further scoring took place, and Guy's finished winners by 4—1.

Guy's Team—Hardy, Wakeford, Sennitt, Parry, Painter, Hewetson, Walters, Wayman, Williams, Couch, Morgan.

In this game the inside forwards were very uneven. At times they were very good, but at others woefully weak. The score in our favour could have been greater.

The wing halves were moderate and they must mark their opposing wing forwards. Painter playing in a strange position, owing to O'Meara being indisposed, played a very fine game and was tireless in his endeavours. The backs were very sound.

GUY'S v. AQUARIUS.

Second Round of Amateur Private Clubs' Trophy.

Played at Honor Oak Park on February 11th. Unfortunately Aquarius were unable to send their first team down, and their reserves proved no match for our full team, who ran out easy winners by 4 goals to none.

The Guy's forwards were always too good for the opposing defence, but they can never have missed so many open goals, as they did in this match. Williams got two goals in the first half on both occasions getting the ball from Walters; in the second half Walters got one and Williams a third. The defence was sound and Hardy brought off a brilliant save. Walters at outside right was the most prominent player on the field.

Guy's Team.—Hardy, Wakeford, Sennitt, Painter, O'Meara, Parry, Walters, Nicholls, Williams, Couch, Morgan.

GUY'S v. OLD CARTHUSIANS.

This match was looked forward to with keen expectations as our opponents are one of the strongest of the "Old Boys'" Clubs.

The conditions under which the game was played were deplorable. Snow and a driving wind were not conducive to good play. Unfortunately our opponents were a man short. Collier, who deputised for Sennit, was far from well, but very pluckily filled the breech.

The game started briskly, the Old Carthusians having the wind and snow in their favour. The play travelled from goal to goal and the opposing goalie had several smart saves to make, but during this half the Old Boys had a greater share of the game. Half-time arrived with no score.

On the resumption the Guy's forwards went off in great style and as a result of combined effort Williams scored with a good shot. From the kick off Couch received the ball and from the half-way line beat the whole of the Old Boys defence and scored with a beautiful shot from twenty-five yards out. The Guy's half backs and forwards continued to play wonderful football, and Couch further increased their lead.

The Old Boys now had more of the play and made several dangerous raids, but the defence held out, Hardy making one good save from a fast oblique shot. So a most enjoyable game came to an end with Guy's winning by 3—0.

The whole team is to be congratulated on its fine performance, but chief credit must be given the forwards who were really brilliant. Williams' shooting was good, and Walker at outside right improves every match, his centering being very fine.

Cross Country.

UNITED HOSPITALS HARE AND HOUNDS v. ROYAL COLLEGE OF SCIENCE ATHLETIC CLUB.

This match opened the cross-country season on February 1st, and resulted in a win for the Hospitals by only one point. The course was the usual five miles of ? country at Blackheath. The Hospital pack, consisting of Housden, Jago, Faull, and Chambers started off at a great pace across the Common, leaving the R.C.S. to follow in more leisurely and possibly wiser fashion. This order was maintained until the first field was reached, when Housden, finding that Jago was his only remaining supporter, gave up packing tactics and proceeded to put a comfortable distance between himself and F. Cooke, the leading R.C.S. man, who was closely followed by Jago. The rest were more or less evenly strung out and finished as follows:—

1. L. .G Housden (Guy's), 34 min. 59 sec.
2. F Cooke (R.C.S.), 36 min. 26 sec.
3. M. E. M. Jago (Guy's), 36 min. 31 sec.
4. J. O. C. Vick (R.C.S.), 36 min. 51 sec.
5. A. B. Clowes (R.C.S.), 37 min. 3 sec.
6. J. L. Faull (Guy's), 37 min. 43 sec.
7. R. S .Chambers (Guy's), 38 min. 4 sec.
8. W. L. Pain (R.C.S.), 38 min. 10 sec.
9. J .C. Hudson (R.C.S.), 38 min. 27 sec.
10. S. E. Theis (Guy's), 39 min. 46 sec.
11. —. Steward (R.C.S.), 39 min. 47 sec.
12. W. W. Darley (Bart.'s), 40 min. 8 sec.
13. A. Simpson (King's), 40 min. 28 sec.
14. —. Griffiths (R.C.S.), 41 min. 31 sec.
15. —. Robb (Guy's), 42 min. 10 sec.
16. —. Oakley (R.C.S.), 42 min. 14 sec.

United Hospitals, 27 points.
R.C.S., 28 points.

Dr. H. A. Munroe kindly acted as starter, timekeeper and judge, and Messrs. Spurrel, Fuller and Strong laid an excellent trail.

U. H. H. & H. v. SOUTH LONDON HARRIERS.

As most members of the U. H. H. & H. are also members of the S.L.H. this annual fixture is always run in very friendly fashion, but none the less pro-

duces some very excellent racing. This year's race, on February 8th, was chiefly remarkable for the duel between Housden and L. Mason (S.L.H.) for first place. Running together from start to finish. Housden just beat his opponent at the run in by 1-5 sec. or 1½ yards. Jago and Martin (S.L.H.) also had a struggle at the finish, Jago just losing owing to the bad habit of looking round.

1. L. G. Housden (U.H.), 35 min. 9 sec.
2. L. Mason (S.L.H.), 35 min. 9 1-5 sec.
3. L. A. Pool (S.L.H.), 36 min. 23 sec.
4. G. B. Hadlee (S.L.H.), 36 min. 36 sec.
5. F. J. Martin (S.L.H.), 36 min. 44 sec.
6. M. E. M. Jago (U.H.), 36 min. 46 sec.
7. R. S. Chambers (U.H.), 37 min. 59 sec.
8. J. L. Faull (U.H.), 38 min. 13 sec.
9. S. A. Greener (S.L.H.), 38 min. 53 sec.
10. A. Simpson (U.H.), 39 min. 6 sec.
11. W. W. Darley (U.H.), 39 min. 11 sec.
12. G. Mc.I. White (S.L.H.), 39 min. 26 sec.

S.L.H., 23 points.
U.H.H. & H., 32 points.

Remaining fixtures—

March 1st. v. Epsom College (away).
March 8th. Inter-Hospital Race for Kent-Hughes Cup at Blackheath.

Hockey.

GUY'S v. BART.'S.

In the return match on our ground at Forest Hill on February 11th, we again defeated Bart.'s, by 3 goals to 1, though playing without four of our regular men and being one short up to half-time. Bart.'s were also weakly represented.

The ground was in such a bad state, that good Hockey was impossible, but Guy's pressed continually. Schollum at centre seemed to enjoy the mud and scored all our goals. Hunt was also prominent.

Slater and Bonnalie were good in defence.

Boxing.

In aid of Guy's Hospital and Insurance Charities, and before a very large gathering of members of the Stock Exchange B.C., United Insurance B.C., Guy's Hospital B.C., and member's friends, a contest was held between United Insurance B.C. and Guy's Hospital B.C., on Monday, February 6th, at "The Rifle and Revolver Club, Bishopsgate. There were two strings in each weight, and Guy's did extremely well in winning by seven events to five.

Bantam Weights (First String).—S. P. Meacock (Guy's) beat J. Vail (United Insurance) on points. A well-matched pair.

(Second String).—M. T. Aung (Guy's) beat A. J. Read (United Insurance) on points in a close match.

Feather Weights (First String).—J. D. S. Thomas (Guy's) beat D. Elliot (United Insurance). The referee stopped this bout in the third round, after Elliot had been severely punished.

(Second String).—C. Gross (Guy's) knocked out S. V. Read (United Insurance) in the first round.

Light Weights (First String).—J. G. S. Thomas (Guy's) beat H. Mason (United Insurance) on points. The late Oxford Captain was opposed by a very useful boxer, but he did enough to gain the decision.

(Second String).—A. Gardner (United Insurance) beat J. C. Mayne (Guy's) in a hard hitting contest.

Welter Weights (First String).—G. V. Lloyd-Williams (Guy's) beat J. J. Fothergill (United Insurance) after three excellent rounds. The judges disagreed, but the referee decided in favour of Williams.

(Second String).—J. Currie (Guy's) beat A. C. Bowie (United Insurance) in the third round of "The Mill" of the evening. Currie was floored in the first round. After taking two counts in the second round, he caught Bowie on the point, but was too weak to administer the "coup de grâce." Bowie started the stronger in the last round, but with a succession of rights and lefts to the jaw, Currie knocked his man out. A very popular and praiseworthy result.

Middle Weights (First String).—H. J. Mitchell (United Insurance) beat H. Trafford (Guy's). After Trafford had received a great deal of punishment from a heavier and more experienced boxer, Alf Hewitt wisely threw in the towel in the second round.

(Second String).—H. Bishop (United Insurance) beat B. Hawkins (Guy's) easily.

Heavy Weights (First String).—C. W. Elliot (United Insurance) knocked out W. H. Summerskill (Guy's) in the first round.

(Second String).—H. J. Mitchell (United Insurance) knocked out N. M. Holloway (Guy's) in the second round, after an even first round.

At the conclusion Sir Arthur Worley, C.B.E., President of the United Insurance B.C., presented pewter tankards to the successful representatives, and in a short speech congratulated the promoters and contestants on arranging such a splendid contest.

Marriage.

MACKINNON—McCLEMENS. — On December 3rd, 1921, at the Garrison Church, Nasirabad, Rajputana, India, Capt. Wm. Calthorpe MacKinnon, M.B., Ch.B., R.A.M.C., to Grace Marie McClemens, eldest daughter of the Sheriff of Canterbury and Mrs. McClemens. (By Cable.)

Death.

TURNER.—On February 3rd, 1922, of Pneumonia following a severe operation, Vivian Turner, L.D.S.Eng., 52, Prince of Wales Road, Norwich.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

AT a General Meeting of the Clubs' Union, held on Feb. 20th, a proposal that the "Clubs' Union Subscription be a compulsory payment by every Student" was rejected by an overwhelming majority, and an amendment to the effect that this proposal should only come into force on and after October, 1922, and not affect those students who entered before that date, met with a similar fate.

We are hardly surprised at this result. To us the introduction of compulsion in the matter of the Clubs' Union subscription seems subversive of the whole idea of a club. One of our correspondents, whose letter we publish on p. 85 considers that there should be no question as to whether membership is optional, arguing that an institution like the Clubs' Union is essential for the community of students, and that "*even* in a hospital" (the italics are ours) there must be a certain amount of discipline. Of course there must be discipline in the Hospital. We have never disputed the question. But we cannot condone a disciplinary measure which compels men to join a club against their will.

We certainly deplore the lack of *esprit de corps* among some of the present generation of students. (Lack of money is with some, a more potent factor than lack of keenness; we do not refer to these). That anyone with any feeling for his hospital can voluntarily abstain from participating or helping in the social and athletic side of hospital life is certainly a great pity. But no amount of compulsion could restore to these erring gentlemen an *esprit de corps* which they never possessed; and compulsion itself is not, in our opinion, consistent with the principles which should govern the constitution of any club.

While opposing the introduction of compulsory membership of the Clubs' Union, we must admit that some other opponents of such a measure use arguments which we cannot support.

A "Thirty-Second Year Man," on page 85, objects strenuously to the idea of paying for somebody else's games. Apparently he regards sport in a hospital purely as a form of beneficial exercise for the individual, and entirely overlooks any effect on the corporate life of the Hospital. Yet one of the most healthy forms of rivalry and one of the surest means of establishing good relations between hospitals can be found in the various inter-hospital competitions. It is very largely through sport that we as students meet and know men of other hospitals, and it is to sport

that we owe much of the good feeling which exists between Staff and Students here. Nothing arouses enthusiasm so much as a Cuptie; even the most sedentary persons often take a tremendous pride in the athletic prowess of their hospital, and watch matches though they cannot play.

A man who basks in an atmosphere of good-fellowship among sportsmen, who is proud of his hospital and supports it when he can, and who enjoys watching his hospital teams and helping them to win even if he cannot play, should be willing to contribute towards their expenses.

If a Guy's man has no pride at all in the prowess of Guy's, and is unwilling to contribute anything towards it, he is unworthy of the generations of sportsmen who have preceded him.

Apparently the reason for the failure of many students to subscribe to the Clubs' Union is a purely personal and selfish one. They, perhaps, do not play games, and they feel that the Students' Club, alone, does not possess sufficient attraction to constitute an adequate return for their expenditure. They feel that they are not getting "value for their money." So they do not join the Clubs' Union. In effect, they say "This club is no good. Let us leave it." Now this is a shortsighted policy. It would be infinitely better to say "This Club is no good. Let us improve it," and to remain members of the Clubs' Union, at the same time attempting to make conditions better by taking a personal interest in the management of the Club. In effecting useful reforms they would be benefiting posterity as well as themselves.

After all, the motto of the Hospital is "Dare Quam Accipere," and we suggest that people ask themselves, "What can we do to improve things?" rather than "What can we get out of it?"

Some people seem to expect all Take and no Put.

The War Memorial Volume of the Reports, now published, will be issued gratis to those students who were regular subscribers to the Clubs' Union from May or October, 1918, to May or October, 1920, inclusive; and also to those who paid one subscription before, or at the beginning of the War, and then returned after an interval due to War Service, to become regular subscribers after the War. These students may obtain copies from the Wills Librarian on and after Monday, March 20th. Any student not in the above category may obtain, for 10/6, a copy from Mr. W. J. Curry in the Counting House.

The Editors of the Guy's Hospital Reports wish us to draw the attention of relatives or friends of those Guy's men who lost their lives during the War, to the fact that a limited number of copies of Part I of the War Memorial Volume, containing Obituary Notices—and in many instances photographs—of those who lost their lives, are obtainable separately from the rest of the Volume, upon application to Mr. W. J. Curry, The Counting House, Guy's Hospital, at a cost of 5s. per copy: or at a reduced charge for a number of copies. Separate copies of Part II, containing an epitome of the doings of each Guy's man who took part in the War are available in a similar way; also at a charge of 5s. per copy. For parts I and II, or for two copies of either Part I or Part II the price is 7s. 6d.

The corresponding prices to subscribers are 2s. for one part, and 4s. for two parts.

We have been asked to draw attention to the fact that a Dancing Matinée will be held at the Aldwych Theatre on Friday, March 17th, in aid of the Newcomen Street Day Nursery. In connection with this there will be an Amateur Valse and Fox Trot Competition. Details will be found on p. 96. It will be seen that a most attractive programme has been arranged.

Guy's men, generally, know less of this Day Nursery than of the "Salomons Centre," whose name, at least, is more familiar. Those who know it, and its work, however, realise that the Newcomen Street Day Nursery is of inestimable value to the Boro' mother, and that a cessation of its activities would be a real tragedy. It will become even more indispensable if the proposal,

contained in the Geddes Report, to exclude children up to 6 years of age from the Schools (instead of 3, as at present) is carried out.

The Nursery, opened in February, 1920, is established in two houses in Newcomen Street, which are the property of Guy's Hospital and let to the Trustees for a peppercorn rent. It has been thoroughly equipped, officially inspected, and favourably reported on by the Ministry of Health. Towards its estimated annual expenditure of £1,200 only about £200 is derived from the 10d. per head per day contributed by the Mothers.

Of the remaining sum the Ministry of Health undertake to provide half, leaving about £500 per annum to be provided by public benevolence. Towards meeting the latter amount the Council earnestly request help.

The care of children has always been of supreme importance to the nation, but never more so than at present. The future of the nation lies in the hands of the children. If they are cared for, and brought up a healthy and contented generation, that future is assured, and emergence from the slough of post-war restlessness and depression is certain.

Child welfare work is a vital necessity in London, and we earnestly hope that the efforts which are being made to provide funds for maintenance and to diminish the debt which still hangs over the Newcomen Street Nursery will meet with a good response. The Dancing Matinée which is being held in aid of this Centre is well worthy of the support of Guy's men, who could contribute to its success by entering for the dancing. Incidentally, they would enjoy it.

We offer our heartiest congratulations to Professor M. S. Pembrey, who has been elected a Fellow of the Royal Society.

The Inter-Hospital Boxing Competitions will take place on Tuesday next at the National Sporting Club. We hope that everyone will do his best to be present, and help our team to retain the Cup which we won last year. The Guy's boxers have had a certain amount of experience in Competition Boxing, and the pitch of keenness among active members of the Club is now as high as it ever has been. Whatever the result, we are sure to witness some really excellent bouts; we wish the Guy's representatives the best of luck.

The first part of an account of the early days of the Gazette, written by an old Guy's man, who knew it in its infancy, is published in this issue. It is always interesting to trace the growth of any journal. The development of the organ which represents any body of men is linked with the changes in custom and outlook affecting succeeding generations, and is, like Pepys' diary, of historical interest. Guy's men cannot fail to be interested in these pictures of life in the Hospital when the Gazette was young.

The Gazette has now completed fifty years of continuous service, a record which, we venture to think, is one to be proud of, especially when we consider the vicissitudes through which it passed in its early days. The debt which it owes to its early editors is incalculable.

The Rugby XV., on Thursday, March 1st, defeated Bart's. by 17 points to nil at Richmond, thus passing into the final round of the Inter-hospital competition.

It is the first time, in our experience, that the Guy's team has shown in an important cup-tie anything like the form suggested by previous victories against well-known clubs. In our two previous matches with Bart's., in the finals of 1920 and 1921, our opponents gave us a very tough fight indeed, and by the adoption of hustling tactics and determined tackling, succeeded in keeping the score down.

On this occasion, however, the most strenuous efforts of our ancient "enemies" were unable to prevent a much more decisive victory—not that they did not play up extremely well and make a gallant fight of it, but they were outclassed. The Guy's XV., though mistakes were made at times, on the whole treated us to as pretty an exhibition of Rugby as we have witnessed for some time.

We congratulate them on their success.

Events of Interest for Fortnight ending Mar. 18.

Mar. 6.—Clinical Lantern Lecture by Mr. Trethowan on "Bone Grafting."

Mar. 7.—*4 p.m., Mr. Cecil Rowntree on "Cancer of the Breast."

5 p.m., Prof. A. D. Waller on "The Energy Output of the Human Body," at St. Mary's Hospital Medical School.

7.30 p.m.., United Hospitals Boxing Competition at National Sporting Club.

Mar. 8.—10 a.m., Examinations:—Junior Proficiency Prize; Michael Harris Prize for Anatomy; Wooldridge Memorial Prize for Physiology.

2.30 p.m., Clinical Lecture by Dr. French on "Pain in the Epigastrium."

3.15 p.m., United Hospitals Hare and Hounds, Race for Kent-Hughes Cup, at Blackheath.

Rugby, Guy's "A" v. R.N.C. Greenwich (away).

7.45. p.m., Beggars' Dance at Knightsbridge Hotel.

Mar. 9.—10 a.m., Examination:—Golding-Bird Medal and Scholarship in Bacteriology.

4 p.m., Dr. Feldman on "The Physiology of the Infant," at the Infants' Hospital, Vincent Square, Westminster.

8 p.m., Pupils' Physical Society, Paper by Mr. A. T. Rogers on "Plague and Pestilence."

Mar. 10.—*4 p.m., Dr. Knox on "Radiation in the Treatment of Cancer."

Mar. 11.—Rugby, Guy's "B" v. Chelmsford (away). Association, Guy's "A" v. Old Owens (away).

Hockey, Guy's v. Dulwich (home). Guy's "A" v. R.E. Chatham (away).

Mar. 13.—1.30 p.m., Clinical Lecture by Dr. Barber on "Bacterial Infections of the Skin, and their Treatment."

6 p.m., Fencing, Guy's v. H.A.C. in Pavy Gymnasium.

Mar. 14.—*4 p.m., Dr. Leitch on "The Experimental Production of Cancer."

5 p.m., Prof. A. D. Waller on "The Energy Output of the Human Body," at St. Mary's Hospital Medical School.

5.30 p.m., University Union Society's Debate at Essex Hall.

Mar. 15.—Rugby, Guy's v. London (Final, Hospital Cup). Guy's "B" v. London School of Economics "A" (away).

Clinical Lecture by Mr. Fagge.

Mar. 17.—*4 p.m., Mr. Percival Cole on "The Cold Cautery Treatment."

Mar. 18.—Rugby, Guy's v. United Services (away). Guy's "A" v. Old Merchant Taylors "A" (away).

Association, Guy's v. Aquarius (Semifinal Surrey Cup).

Hockey, Guy's v. Royal Observatory (away). Guy's "A" v. St. Bart.'s "A" (home).

Change of Address.

Correction.—In the last number of the GAZETTE it was wrongly stated that Dr. C. P. Symonds had changed his address. The announcement should read Sir Charters J. Symonds, K.B.E., C.B., M.D., to 14, Portland Place, W.1.

A. P. Marsh, Ivy Cottage, Exeter.

C. E. Edwards, M.D., Elvin House, Andover, Hants.

Papers by Guy's Men.

A. Ralph Thompson, F.R.C.S. Some Urgent Urinary Cases.—*Clinical Journal*, li., 1922, p. 73.

Relief Fund for Teachers of Science and Medicine in Vienna.

	£	s.	d.		£	s.	d.
Subscriptions received	30	14	0	Dec. 17.—To Friends' Emergency Relief Fund	9	0	0
				Dec. 30.—Ditto	15	0	0
				Feb. 19.—Ditto	6	14	0
	£30	14	0		£30	14	0

Examined and found correct,
MAURICE E. SHAW.

Publications Received.

The Hospital Gazette, The Nursing Times, British Medical Journal, Architectural Association Journal, St. Thomas's Hospital Gazette, The Serpent (Manchester University), The Stethoscope (Bristol), Hospital and Health Review, Nursing Mirror, New York State Journal of Medicine, London Hospital Gazette.

*Clinical Lectures at Cancer Hospital, Fulham Road, S.W.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—There seems something almost attractive in the ingenuousness of the proposal to make the Clubs' Union subscription compulsory. The Clubs' Union, in effect, says, "We haven't enough money. *You* must give us some." There is no thought of cutting their coat to suit their cloth. If they cannot afford to do all they are doing, there are several possibilities open to them; they can economise all round; they can cut out the expensive items of their programme; or they can increase their income by (a) raising their subscription, or (b) widening their subscription list. This last they can effect (perhaps) by either increasing the value offered or by making subscription compulsory.

Now why is there this necessity, anyway? What *is it that costs the money? If it is the games*, then the unwilling subscribers will be paying for other people's games. The idea of the soccer eleven going round with bludgeons to raise the price of a new ball, or the rugger secretary passing the hat to collect the expenses of last week's matches is perfectly fantastic. But it is much the same thing if the subscription is made compulsory. Somebody will be paying for somebody else's games. And *that* doesn't sound at all nice.

Perhaps it is the other branches of activity which are so expensive. To this there are two obvious retorts. They are that the result is pretty poor, and that if so why should not those who benefit by them pay for them? In fact, this is the great point. No one should obtain anything from the Clubs' Union unless he bears his proportion of the cost. *This cannot be the rule now, or else the Clubs' Union would not be in need of money.*

The Clubs' Union also says that unless compulsion is introduced, they will have to employ a steward to see that no non-member enters the Club, and that this additional expense is beyond them. So by compelling all Guy's men to join, they will obtain the money for this man's salary and at the same time obviate the need for his services. And *that* doesn't sound at all nice, either. Not even the most rabid Imperialist would approve of England trying to conquer France under the plea that, were France a province, custom house inspectors would not be needed on the Dover-Calais route.

Anyway, the Clubs' Union does not provide sufficient accommodation for even their present membership. How many teams can we run at present? Who remembers the congestion on the tennis courts last summer? Expansion is promised, it is true, but *proportionate* expansion is insufficient. And who, having suffered under the Clubs' Union at present, will believe that when it has lost even the spur of trying to obtain new members, it will exert itself to satisfy the needs of its greatly increased clientèle?

These things apart, compulsion is obviously undesirable. The Union could increase its subscription enormously without fear of losing members: and, anyone expelled from the Club, would, of course (since he was not paying his subscription), be automatically expelled from the Hospital. No person or body should be entrusted with so much power. In the consideration of this matter, sanity is all that is needed. Let everyone remember, the Clubs' Union *is an adjunct to the Hospital*. not the Hospital to the Clubs' Union.

A THIRTY-SECOND YEAR MAN.

SIR,—As one who is proud to be an old Guy's man and believes it to be "the only Hospital," your article on membership of the Clubs' Union surprised me. I cannot agree that there should be "no infringement of individual liberty." You will observe that I am writing from one of H.M. ships; to be a student at Guy's should place one in identically the same position as a member of any Service Mess. So many present students must have seen service that I think that they will agree that there are several subscriptions which (if they possess *esprit de corps*) they must recognise as compulsory. An institution like the Clubs' Union is so essential for the community of students that there should be no question as to whether membership is optional. It should be included in the schedule of fees, and those objecting have their alternative at the commencement of their career. To use Guy's as a type of L.C.C. Continuation School, being "in" the Hospital, but not "of it," to me seems deplorable. I have received my GAZETTE so late that the meeting has already taken place, but I would suggest that there should be no difficulty at all in differentiating between playing and non-playing members; the latter should have admittance to H.O.P. merely as spectators. The declaration as to which class could be at the individual's discretion, and surely his *amour propre* would prevent him from using privileges to which he was not entitled. There must be a certain amount of discipline even in a hospital, and it should be easy to devise a suitable reply to those who can't play the game.—Yours truly,

SURGEON-COMMANDER, R.N.

Guy's Hospital Dramatic Society.

The Guy's Hospital Dramatic Society gave two very enjoyable performances in aid of funds for the new Tennis Court, on Wednesday and Friday evenings, February 15th and 17th, in the Nurses' Home.

The Entertainment consisted of two parts, the first being a One Act Farce, entitled "Sally's Peppermint," which was given by some enterprising Nurses. The plot was laid in a Chemist's shop, the owner of which had been called away on business, leaving a servant and charwoman in the house, who were given strict injunctions that no one was to be served with medicines.

The part of Sally Rylott, the charwoman, was taken by Nurse Garbett, who caused great laughter by the ingenious way in which she mixed the medicines left for the boy to deliver, replacing a broken bottle of liniment with a bottle of cold tea, and making up a bottle, which she styled "Peppermint," consisting of peppermint, Epsom salts and other nauseous ingredients, for a neighbour with whom she was on bad terms. In answer to an urgent request for a powder for a sick child, she handed out a small packet from a drawer, nearly killing the patient. This was the cause of great commotion in the village and brought on to the scene Inspector Hooker, a friend of Mr. Quack, and therefore anxious to hush up the matter. Nurse Pickard took the part of a cool and collected police official making copious notes, in a most approved style. Nurse Dreebin, as Betsy the maid, caused much laughter when her curiosity tempted her to taste the peppermint Sally had made up for her friend, and found it not so palatable as it should be.

The part of Sally Bruff was well sustained by Nurse Eynon, as was also that of Mrs. Tutty (by Nurse Cruse), a customer who received a package of linseed instead of a box of pills. Nurse Mundy played the part of Joseph, the errand boy, in a most successful way, her sharp dialogues with Sally being much enjoyed.

Nurse Hacker took the part of the suave Mr. Quack the chemist, who, on his arrival home to find his shop invaded by a police official and irate customers, smoothed over all the difficulties by suggesting that as Sally's medicines were not so dangerous as they might have been, she should be made to take them herself.

The second part consisted of a Farce in one Act entitled "Uncle Ben," and was given by the Sisters. The plot was laid in the Sitting room of a Boarding House, in which two medical students lived, one of whom, Montgomery Fitzgerald, received a letter from a rich American uncle who had come over to England for a few days, and wished to pay him a visit and make the acquaintance of his wife. As the wife did not exist, and was only an excuse to get an extra cheque from the uncle, his nephew was placed in a very awkward dilemma, and after a great deal of persuasion, got his chum Freddy Rodleigh, to play the part of his wife, which he did so successfully that the uncle left behind him a big cheque, and also a present to Freddy for acting the part of the wife so well, but not sufficiently well to take the uncle in.

Sister Theatres (Miss Evershed), was excellent in the part of Montgomery Fitzgerald, and caused much laughter by the ingenious way he got round several nasty questions. Sister Dorcas, as Freddie Rodleigh, played the part of the newly married wife exceptionally well, her evident disgust and discomfort at having to wear feminine attire was well assumed. Sister Naaman (Miss Dearman) as Mr. Benjamin Poddles, the rich American uncle who could not be taken in, was extremely good, and the way in which he managed to evade his wife and make friends with pretty girls was most amusing. Sister Agnes (Miss Verinder) was very successful in her part as the American aunt, and her questions regarding the bride's dresses, and the wedding of her nephew, caused much consternation to that gentleman's supposed wife. Sister Luke (Miss Olive Wilson) made an excellent landlady, and the way in which she opened her boarders' letters and read their contents, was most amusing.

Sister Patience (Miss D. Smith) and Sister Kathleen (Miss Burton), took the part of the chums' financées, and their enjoyment at seeing Freddy as a newly married wife, caused much laughter.

During the interval, selections of music were given on the piano and violin by Sister Mildred (Miss Hughes) and Sister Winifred (Miss Johnson).

Vacuous Verses.—IV.

Triolet to Anatomy.

(With apologies to Dr. Robert Bridges.)

When first we met I could not tell
That you would prove so hard to master;
In pondering thought I'd nightly dwell.
When first we met I could not tell
That many months I'd labour well,
Nor learn your secrets any faster.
When first we met I could not tell
That you would prove so hard to master.

When the "Gazette" was Young.

PARENTAGE.

I remember well the birth of the Guy's Hospital GAZETTE. It happened, I think, just about fifty years ago. For a long time it was a puny, weakly infant, and suffered severely from a poor circulation, as well as many minor disorders incidental to the period of infancy. Lack of a proper amount of support often threatened its existence, and had it not been for its parent's friends coming to his assistance, its existence must, on several occasions, have flickered out. It was not by any means an unpopular infant, though. Everyone was pleased to meet it, and hail its advent with delight, but few realised that it was a severe tax on its single parent's time to provide it with adequate means of support. The capacity of its columns seemed incredible, and the small type of its early numbers absorbed such an amount of copy that its regular appearance was at times a difficult matter to keep up. I remember distinctly the author of its existence. His name was Cattell; he entered Guy's, I think, in 1870 or '71. It was entirely a private affair, unheralded by any previous announcement. At first, although welcomed affectionately by the students, the expense of its upkeep was more or less of a drain on the pocket of its parent, nor could it for many years ever be looked on as a source of income.

I believe it was the first of its kind in London, and though it was often a struggle to keep on, it has done what many of its rivals, imitators, and even opponents, have not done, it has had a practically unbroken career and kept on its feet from the beginning.

EARLY EDITORS.

The GAZETTE itself was always popular enough, and nothing could excel the kindness with which it was received, but the difficulty was to find a suitable foster parent who had spare time and was willing to give it up to the weakly infant. In no sense can it be said that when Cattell left and bequeathed the GAZETTE as a legacy to the Hospital, that he thereby relinquished any part of his income. There are not very many left now who can speak with familiarity of the inner life of Guy's in those days.

THE ROOMS.

The focus of all things pertaining to a student's existence and work was "The Rooms." With the new College the glory and attraction which the Rooms had for all Guy's men has departed and, with them, all the old traditions and memories which cling so strongly to even the chairs and table. It was the ambition of every first year's man to some time enter them in his own right. Around them, and the student officials who tenanted them, hung a cloud of reverence which was sacred. Its traditions were numerous and held in veneration. The Head of all was the House Surgeon; next came the Senior in the Charity. These two dignitaries occupied the two big armchairs, one on each side of the fireplace. The Junior H. S. had the smallest of other two; the Junior in the Charity the larger, padded one. The dresser for the week took the sofa, as his rest was supposed to be most broken, and the ex-dresser the small plain dining-room chair. There was but one H.S. in these days. He acted for all the surgeons and held office as senior for two months, in addition to his two months as junior, when he looked after the Surgery.

(The tradition from Junior House Surgeon, which was a post of no authority at all, except in the Surgery, to that of Senior House Surgeon, which was the most responsible position a student could obtain, making him the head of the Rooms and the responsible officer in all the Surgical Wards in the absence of the Staff, was so great that it was by custom imperative to effect the change at a distance from the Hospital.

So well was this understood that the Manager of the London Bridge Railways always granted the Junior H. S. a return first-class ticket to any station he might select in which to spend a few days of rest. So, leaving a few days before his term of office as Junior H. S. expired, he quietly slunk away a nobody, and came back in the full glory of Senior House Surgeon. In this again beneath the romantic reason ascribed, viz., that of keeping up the hospital traditions, we find lurking the true origin. It is a necessary and very acceptable break in the work. After a man has spent two months in close application to duty inside the walls of a hospital, he is more or less run down in condition, and a few days of rest spent by the sea is a wise precaution to take before embarking on a still more arduous

two months. By making it "customary" and "traditional" it is at once obeyed by it being lifted from a debatable ground to a fixed law. There can be no doubt that in all tradition there is a foundation of empirical truth.)

A dresser was in residence for two weeks; the first one as Dresser for the Week, when he was a pampered person, being served first at dinner and so on; the next week he was the ex-dresser, when he had to perform all the menial offices at the Rooms, such as mending the fire, drawing the beer, keeping the tobacco jar filled, etc., all of which I never saw performed except with the best grace and utmost good temper. The menial office was always accepted with Homeric dignity—this sudden fall from the pet of the table to the common servant. It reminded me of Longfellow's "King Robert of Sicily" more than anything else. The "Charity," likewise, had to superintend the supply of tobacco, pipes, and extra luxuries for the table.

The Weekly Bills.

For although the authorities of the Hospital supplied free to the residents board, residence, etc., which included ample plain food, beer, and a decanter of sherry daily to each resident, there had to be a fund raised among themselves for the purchase of such delicacies as jams, biscuits, potted meats, olives, Burton ale, etc. (the hospital beer was given to policemen, porters, etc.; personally I preferred it to the Burton ale); in fact, anything which might be approved of by the Charity. Sometimes when the weekly "bills" got too high, they had to be cut down; as now and then delicacies quite unnecessary and expensive have been demanded. I have known the "bill" of each resident get as high as 16s., which was a large sum in those days, for an appointment where "board and residence" were provided. This meant a total weekly expenditure for eight residents of £6 8s. In fact, I was told by the Superintendent that a timid or shy man had been known to refuse the offer of one of these high posts on the ground that he was too poor to pay the weekly bills. In my day there was a very strong tendency to get the bills higher. More than one acrimonious discussion has arisen on the Charity insisting that these voluntary, and yet compulsory, debts should be kept within quite reasonable bounds.

Traditions.

Many a humorous situation was provided by the performances of these traditional duties, discharged with such good and willing graces, that they were looked on rather as an honour than a humiliation. I once saw a most genial man of culture and refinement, a double-first of Oxford, when acting as "Charity," answer the question of "Where are you going?" by turning round at the double door and saying in his high-pitched falsetto voice, with a broad smile on his face, "To buy pipes; only fancy me going to buy pipes, I, who have never smoked a pipe in all my life!" He has for many years been retired from the executive staff of the hospital, and later of life itself.

I remember some of the most cherished of axioms for residents, which were always implicitly obeyed, though entirely traditional and never expressed—

Pipes only to be smoked; no cigar or cigarettes. Only beer drunk before dinner and then wine or water. Never spirits at any time. Certain rules as to conversation at dinner were enforced by fines. Dessert was taken in the next room to the dining-room. On entering this "withdrawing" room the chairs were always found drawn up in one certain fixed position, and the dessert laid. Each one then of the residents took his own special chair and occupied it until dessert was eaten. This was a very strict rule. It would have been looked on as a piece of the grossest impertinence for, say, a dresser on coming in to dessert to sit down on a seat that did not belong to his office. In fact, I never knew it broken.

Though the "Common" Room might be crowded during the afternoon, all visitors withdrew as the dinner hour approached and any non-resident would as soon have thought of standing on his head as remaining in the outer room after the residents had gone upstairs to wash, or re-entering it before dessert was cleared away. All men who had been resident, or who were the friends of residents, had the entrée of the rooms, and for them the ex-dresser drew beer and provided tobacco. There was always a rubber of whist every evening and very good whist too. "Cavendish" (a nom de plume for Dr. H. Jones) was freely quoted and recognised as the one authority.

The evening rounds began at nine o'clock, and tea was laid during absence in the wards.

It was on this meal that the subscribed money was chiefly expended, and the long table was covered with a large variety of jams, biscuits, potted game, sardines, etc. No one began tea until the H. S. returned from the wards. His entrance was a signal for tea to commence. I remember one who invariably kept us waiting till 10.45, which provoked some remonstrance. He promised amendment, but soon relapsed. He was very hypersensitive in the performance of his duties. He was recently laid to rest, after a long career of work and teaching; never robust, but an indefatigable worker.

The appointment of House Surgeon was one of great value in many ways to a student about to start in life on his own account, and the holder of the office always tried to maintain the high standard of efficiency. I never remember a lax H. S., but such laxity would have been deeply resented by all the Seniors. The H. P.'s were newly created, and non-resident. They had no "chairs," and their appointment, though valuable from a practical point, carried little or no dignity from a student's point of view. It was overshadowed by the H.S.

Not so the dressership. It was a most valued appointment, and one held in great respect by virtue of the large amount of practical work done in the wards and theatre by the dressers. More especially was this applicable to the dresserships to certain particular surgeons. One Surgical Registrar told me that he might have been dresser twelve months before he allowed himself to be appointed, but he preferred waiting until he could be appointed to John Hilton whose dresserships were most highly valued.

I was not an eyewitness of the following incident, nor did it happen in my time, but it was told to me by one, very many years my senior, whose position in the hospital puts it beyond dispute. In fact it was no other than old Mr. Stocker, "Jimmy."

It was the day after the new appointments had been made that Hilton asked Stocker "What sort of men are these you have given me this time? One of them looks rather too fine and delicate to be much good, I think. I don't care much for such dandies." Stocker assured him that he had done good work and passed his exams very creditably.

"Ah, then," said Hilton, "I will see what I can do with him." An opportunity soon presented itself. One of the cases which fell to the lot of the young "swell" was a large and foul ulcer of the leg. Anyone who has read that wonderful book of Hilton's, "Rest and Pain," knows what a splendid teacher he was on that and a hundred other topics. On this occasion he spoke earnestly of how we may often learn great truths from small facts. How, in offensive common diseases we often omitted that searching examination which might be given to them. "The smell of ulcers, for example," he said, "is most distinctive and instructive. Have you observed the smell of this one? Do so." The dresser, with disgust, held his nose about a foot above the stinking leg. "That is no good," said Hilton, "closer, closer yet, quite close," he kept repeating, until the dresser's nose was close upon the sickening area of septic pus, which was almost equal in size to the dresser's face. No sooner had his countenance got close enough to the sore than Hilton, rapidly placing his left hand under the leg and his right upon the dresser's occiput, firmly rubbed his nose and face into the ulcer. The indignant dresser sprang up and squared his fists to attack Hilton, but the ringing laugh of the crowd of students, who thoroughly appreciated the treatment of this delicate fop, as well as Hilton's burly frame, made him adopt wiser counsels, and, with the encouraging help of the surgeon, he adopted more practical methods and became a dresser after Hilton's own heart.

Mr. Stocker was very old when he told me this, and it may have "improved" with age, but it has the genuine ring of a true Hilton story. So, "Si non e vero, e ben trovato." He was a fine surgeon and a fine teacher. No one can look at Towne's models of his dissections without fully realising that.

(To be continued).

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor. "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

The Dental Dinner.

The 1922 Annual Dinner of the Guy's Hospital Dental Society is now a thing of bygone days, and all that remains is a hazy recollection of old friends met there; of toasts that were given, and responded to; a succession of orderly dishes most savoury and with unpronounceable names; a wine list; a bill; an exchange of much hard cash; a mad scramble for autographs; a weary journey homeward.

But it is not so difficult to recall the events of that evening.

Mr. F. J. Pearce in the chair, opened the evening with a toast to His Majesty the King, and followed almost immediately with another to the Queen, and the other members of the Royal Family.

Then at the far end of the first table rose Mr. A. E. Rowlett, to give the toast of the Dental Society. He spoke in warm terms of Mr. Pearce, who held the chair, as President of the Society, and of the Society itself in regard to the benefits it conferred upon its members and ultimately of "Dentistry as a profession—the finest profession in the world!"

To this toast Mr. Pearce responded, thanking Mr. Rowlett for his remarks. He than gave a brief account of the Society's progress, its present status and its significance, how it formed a training ground for the larger sphere of work and interest awaiting us in the British Dental Association. He spoke upon politics, internal politics as regards the detrimental five guinea Clubs' Union subscription; external politics as regards Dental Registration, and the B.D.A., and the men who had accomplished this task through unceasing effort—Mr. Dolamore, Mr. Hopson, Mr. Bennet among the foremost.

Mr. W. H. Dolamore arose to give a toast to Guy's Hospital and Schools. He spoke of Thomas Guy as of an old friend, and gave more than a laughable portrait of the character of this extraordinary man. As I pass the statue of Thomas Guy in the front entrance to Guy's, and gaze up at his blackened and immobile face, I look intently, for some small sign of the inner nature that Mr. Dolamore described to us, but I look unsuccessfully. The statement that Guy's got its money by the skin of its teeth, was greeted with much laughter.

Mr. Dolamore considered critically the fact that Guy's with its manifold advantages, had not given birth to any epoch making discoveries. A kindly criticism in that it urges one to further effort, and yet unkind, in so far as science is as much in need of the small and unobtrusive observations, as of the epoch making and the dazzling discoveries that Mr. Dolamore would have us make.

Dr. J. Fawcett rose to thank Mr. Dolamore for his words, and continued the discussion in regard to the work being done at Guy's. He emphasized the need of extension and spoke about the Voluntary Hospital System under which we exist at present, pointing out the evils that would result in State Control.

Mr. J. B. Parfitt gave a toast to the visitors, and was responded to by Lt.-Colonel J. P. Helliwell.

Mr. M. F. Hopson arose to give a toast to the Chairman, Mr. Pearce, and throughout his discourse upon the good work that Mr. Pearce had been engaged upon in connection with the B.D.A., he kept his audience rocking with his jokes and admirably chosen witticisms.

Mr. Pearce responded and a few minutes later gave a toast to Mr. Helder, the Secretary of the Dental Society. The Society, he said had always been successful in its choice of Secretaries, but in this case was it exceptionally so. He further indicated the high position in which Helder stood in the sporting world of Guy's, and what he had been engaged upon during the war. Mr. Helder replied to the toast, and was loudly cheered.

The entertainment provided for the guests was well appreciated, and its merit enhanced by the fact that the artists, were all Guy's men who had stepped forward to offer their talent; both voluntarily and wholeheartedly, for the success of the evening.

Mr. A. S. V. Daniels at the piano, Mr. J. S. Dick as cellist, Mr. W. H. Bradfield a baritone, and Mr. F. F. Brayfield with his monologues, all contributed to the success of the musical numbers and the appreciation of their audience was manifested by the applause they received.

In conclusion, I can only remark that the success of the evening—and it was an undoubted success—was due to the enthusiasm and energy of the Chairman, Mr. Pearce, and his efficient Secretary, Mr. Helder.

Queer Things in Spain.

Every country has its peculiarities and Spain is no exception to this. It is a country of laughter *par excellence*. Battle, murder and sudden death, all provide entertainment, and nothing is allowed to interfere with the joyousness of life. Once I snatched a knife out of a butcher's hand as he was about to stab a comrade in a quarrel, surrounded by a laughing crowd of men and women. At a hospital in Seville I have seen gay laughing lepers, laughing with half a face. I have seen a comic fellow, smiling jovially, speechless from tuberculosis. Everything is a subject for mirth in Spain. At Barcelona, I saw a horse in a tradesman's cart trotting gaily along with a happy monkey seated on his back.

In the theatre in the same place I saw a lady in the stalls eating raw eggs out of a paper bag during the performance. They are a sober people and I only remember seeing two drunken natives in two years. In France, a cat is regarded as a pet; in Spain a cat is a hunted animal and is considered an inferior kind of rabbit and killed and eaten as such. Birds on the other hand are held in great regard.

There is a curious sort of barnacle much in favour called "Percibe." It consists of a black stumpy glutinous mass with white shell on one side. It looks, to the ignorant, exactly like a nigger's toe. This is a favourite dish at Bilbao, and is by no means unpleasant. Cuttle fish with ink sauce is quite good eating, while large wood lice are eaten with great relish at Malaga.

For the funerals of the poor at Bilbao was provided an universal coffin with a false bottom working on hinges and fastened with a bolt. The coffin with a corpse inside was lowered into the grave, and after the bolt had been drawn, the coffin was pulled up leaving the body still in the grave. A friend of the writer once saw an accident with the trick coffin. As the corpse was being carried up the steps of the parish church, the bolt at the bottom of the coffin became unfastened, with the result that the corpse fell out. A truly gruesome sight. In Spain, if you admire any article belonging to your host, he immediately offers to give it to you. Should you however accept the offer he loses his sense of humour, and for once a Spaniard does not smile.

FREDERIC VICARS.

Reviews.

Medical Examination for Life Insurance. By T. D. Lister, M.D., M.R.C.P. (Messrs. Edwin Arnold & Co., 1921.) Price 10s. 6d.

Few who practice medicine in any of its branches fail to be called on, at one time or another, to take a part in the machinery of Life Insurance. The most private practitioner may be asked, with his patient's consent, to tell the Life Office to which a proposal has been made, the nature of an illness for which the applicant has been treated and the impression then, or subsequently formed as to his prospect of longevity. Not many men are so busy that they are unwilling to accept an appointment, if offered, to act as a local examiner to whom may be referred for a medical report any persons resident in his neighbourhood desiring to take out a policy. For the position of chief medical officer to an insurance company there is keen competition amongst consulting physicians, the work being of a highly responsible character and demanding wide experience and sound judgment. For the benefit of this last class there is developing, especially on the other side of the Atlantic, an extensive literature, the output of learned societies devoting special attention to Life Insurance problems. The Medical Departments of the larger Companies issue valuable statistics based on the actual results of the business undertaken in past years.

The knowledge thus acquired has encouraged the Insurance Companies to-day to make much greater demands on their Chief Medical Officers than was the case in the last generation. Formerly, all that was asked was that the existence of any specially hazardous feature in the case should be detected in order that the applicant's proposal might be rejected. Nowadays the exact nature of the special hazard has to be determined and the possibility of meeting it, by raising the cost or shortening the period of the insurance carefully explained. As a guide to this difficult task no single small volume can be of any material assistance.

Dr. Lister's readable little book on Medical Examination for Life Insurance is addressed especially to general practitioners who, as private attendants or local examiners, provide the information on which to a large extent the Chief Medical Officers must depend in determining the advice that they shall give to their companies. Strictly speaking these attendants or examiners are not concerned to form an opinion as to the terms, if any, on which the cases they examine can be accepted or whether indeed they should be definitely rejected. It is, however, becoming generally agreed that in this age of specialisation in all forms of work no man can be expected to take a proper interest in his job unless he is allowed and encouraged to understand the true bearing of his own bit, however small, upon the completed task, however complicated. Dr. Lister, therefore, does well to give to his readers some insight into the work, which he and his fellow Chief Medical Officers will have to do after the practitioner on his part has thoroughly examined the applicant and filled in to the best of his ability the form which seems so extraordinarily complicated until one has got used to it.

This insight into the task of the Chief Officer will lessen the practitioner's natural irritation at the numerous questions he has to answer, the true bearing of which may not be obvious at first sight. But as Dr. Lister truly says, the examiner's real task differs but little from his everyday work of accurate observation and careful record which form the essential basis of all clinical work. Viewed in the light of their true objective of arousing the interest of medical examiners in their routine work Dr. Lister's observations on the effects of various anatomical and physiological changes, family his-

tory, habits and occupation upon a man's prospect of insurance will serve a very useful purpose. If they were intended to be used—it is clearly stated they are not—as a guide to a Chief Medical Officer in reaching a decision as to the rating up of individual cases it would have to be recognised that they are personal opinions of an experienced adviser upon matters as to which the experts differ as much as they do in other branches of medical science.

The Golden Rules of Dental Mechanics. By Harold Orsborn. (Messrs. John Wright and Son, Ltd.) Price 5s.

This book may be of interest to Dental Mechanics setting forth, as the author explains in his preface, a number of useful practical hints in connection with the details of routine work in a Dental Laboratory.

They are small facts, and apparently insignificant, but in the course of a day's work, it is the application of details which is responsible for the economising of much time.

It is quite a small book, and is not intended as an extensive manual on the subject, but rather, as a collection of hints, which would otherwise be gained at the expense of much time and trouble on the part of the novice at Dental Prosthetics.

Dental Registration. By Kingsley Wood, M.P. (Messrs. Bailliére, Tindall and Cox.) Price 5s.

This book has been written as a short guide to the New Dentists Act of 1921, and fulfills its perpose admirably in the clear and concise way in which the facts have been set forth.

It also contains chapters on Registration, the Rights and Duties of a registered man, the Unqualified Dental Practitioner, the Dental Mechanic, Dental Companies, the Dental Board, and the General Medical Council, and a few general legal explanatory notes.

It should prove of value to those who wish to understand the provisions of the Act as it affects the various classes of unregistered persons. It informs those wishing to claim registration under the new Act, of the necessary legal procedure. It may also prove of value to those who wish to prevent ineligible persons from becoming registered.

It can indeed be looked upon as a practical guide to the new Act, and the author is to be congratulated on the manner in which the facts have been presented.

Aids to Medicine. Third Edition. By Bernard Hudson. (Messrs. Baillière, Tindall, and Cox.)

This small book, as the writer points out in his preface, and as the name implies, is merely intended for the purposes of revision. The subject matter is accurate except in one or two instances, e.g., the writer states that the pulse in typhoid is rapid (p. 4, l. 7) whereas most authorities agree that the slowness of the pulse in typhoid is a sign of considerable importance in the differential diagnosis of the disease. The signs and symptoms are given concisely, and the book contains several useful tabulated lists to aid in diagnosis.

It is always difficult to dogmatise as regards treatment, but the author is inclined to err in the opposite direction; and in quite a number of instances he commences by saying "The treatment is very unsatisfactory," a statement which does not assist the student, or indicate to him the lines he should pursue in his treatment of the case.

The book is undoubtedly of use to those about to take the Final Medicine, as, on account of its size it can conveniently he carried about, and it contains a maximum of information in a minimum of space, but it is not a book one would recommend for use by a junior man. Its chief merit is merely in refreshing the memory with regard to minor details, after a fair knowledge of medicine has been obtained from the recognised classical text books on Medicine.

The Treatment of Common Female Ailments. By F. J. McCann, M.D., M.R.C.P., F.R.C.S. (Messrs. Edward Arnold and Co.) Price 8s. 6d.

It is generally agreed that the majority of text books on gynæcology devote too much space to descriptions of morbid histology and to the elaboration of speculative hypotheses and all too little to questions of treatment other than surgical. It is equally well recognised that there exists an inherent difficulty in allowing every student adequate opportunity of co-operating in the examination and treatment of women hospital patients. The inevitable result is that the young practitioner finds himself less well equipped to deal satisfactorily with illness among his female patients than any other branch of his practice.

Dr. F. J. McCann, in a small volume entitled 'The Treatment of Common Female Ailments," attempts to supply the need for practical advice on this subject. The author discusses briefly and concisely every important condition upon which the practitioner is likely to be consulted, and makes recommendations for their alleviation and cure. Some of the ideas on pathology are open to criticism, and some readers may object to the multiplicity of remedies suggested, but it is not difficult to select the lines of treatment which have the whole-hearted backing of the author's mature experience.

We feel confident in recommending this publication to the busy family doctor, who will find what he wants set out in explicit detail and in a readable

form within its covers. The publishers are to be congratulated upon a well-produced book at a moderate price.

The Dictionary of Practical Medicine. By Many Writers. Edited by Sir Malcolm Morris, K.C.V.O., Frederick Langmead, M.D., F.R.C.P., and Gordon Holmes, C.M.G., C.B.E., M.D., F.R.C.P. (Messrs. Cassell & Co. 1921.) Three vols. Price £5 5s.

Sir Malcolm Morris and his co-editors set themselves a herculean task when they decided to condense all the medicine, old and new, that the practitioner required, into the compass of three crown quarto volumes. They have accomplished their task with a commendable measure of success. Glancing at random through the pages of the work, it is difficult to find any subject which is abstruse and which is not adequately discussed. Each subject has been allotted to a recognised authority, and yet, despite this diversity of writers, the whole book maintains a singularly uniform character. What is most noticeable is that in every article no matter by whom it be, it is the practical side of the question that is stressed. The etiology and pathology of the condition may be mentioned, but they are not emphasised; the lion's share of the available space is kept for the all-important questions of diagnosis, treatment and prognosis. Thus does the dictionary justify its title, and thus it will justify the popularity which it has already gained and which it will continue to gain among medical practitioners.

With regard to the make up of the books themselves, little fault can be found. They are bulky, but they must be so. There is a vast amount of cross-reference, but in such a work, cross-references cannot be avoided. The paper and print are pleasing, the illustrations good. Altogether the books are well worth purchasing; in the long run they cannot be counted expensive, for they embody more useful matter than could be obtained from a score or more of books on medicine, surgery, or the individual specialities.

Football.

RUGBY.

GUY'S v. PLYMOUTH.

On Saturday, February 11th, the Hospital team with many reserves from the 2nd XV., made the long journey to Plymouth. Though beaten the men who played for the Hospital were not disgraced and are to be congratulated on doing so well. Plymouth Albion beat us by 2 tries to nothing. Albertijn played at stand-off half, Steyn in the centre with Van Schalkwijk. The backs brought off many good runs, but the forwards were much overweighted and out-paced. Plymouth have about as heavy and hard a pack as any playing to-day. The tackling of the Hospital men, however, was good and one try was the sole score against us before ends were changed.

The second half was also, to a considerable extent dominated by the big forwards opposed to us and again a try was registered by the home XV. Our men strove must manfully to turn the tide. Many bouts of passing and much splendid work was done, but the score sheet, as far as Guy's were concerned remained a blank and we had to admit defeat by the margin of 2 tries or 6 points to nil.

GUY'S v. DEVONPORT SERVICES.

Remembering how in November, at Honor Oak Park, this Services XV. ran us to a draw and defended so thoroughly and well, Guy's made no mistake about attacking in this match at Devonport on Monday, February 13th, 1922. Extraordinary to relate, however, the home team again concentrated on defence, trusting to luck that sooner or later opportunities would come their way to score. In this game again and again our threequarters seemed certain to score but on every occasion the attempt fell short of success. The Devonport men achieved a couple of good scores before the interval. Happy and Eyres were the actual try-getters and Kealey kicked the goal from the last try. Neser gained a try for Guy's before ends were changed, and afterwards Steyn got a try, some distance from the posts. As no conversion followed we were beaten by the margin of the successful kick. The side seemed a little tired after their exertions of the previous Saturday against the Albion, but the real reason of our defeat, apart from the unsuccessful kick, was the magnificent defence (tackling and going down to the ball) of these Services men of Devonport.

In this game Van Schalkwijk was stand-off half. H. K. Williams was to have played at threequarter as Hirschberg had returned to town. But Williams got "'Flu." and Neser gallantly played in the threequarter line, and played well too. It will be seen that the side was not anything like at full strength. All the more reason why Guy's men should be proud that the second strings did so well.

The names of those who made the trip were:—A. K. Van Niekerk, A. Daneel, P. K. Albertijn, C. L. Steyn, A. Hirschberg, H. K. Williams, E. L. Sprong, F. Bekker, W. H. Taylor, F. J. Biddle, E. E. Neser, P. G. Harvey, A. Zondagh, F. J. Hutchinson, R. V. Cookes, L. B. Helder, H. G. Close and N. M. Holloway.

GUY'S v. MIDDLESEX.

Senior Inter-Hospital Cup—2nd Round.

This match was played at Richmond, on Thursday, February 16th, so it will be seen Guy's had not long rested after their week-end exertions at Devonport. H. Graham-Davies and F. J. Biddle were unable to play. Space will prevent a very detailed report as so many matches have been played recently, it is a little difficult to insert them all in detail.

To begin at the end Guy's won by 23 points (1 goal and 6 tries) to nil. Only six points were obtained before the interval. The Guy's team were all the time trying to cross the line. Middlesex were all the time trying to prevent it. No time

was available to try much in the way of attack. Middlesex concentrated on defence and in that were so far successful as to keep the scoring down. The two tries were gained just before the half-time breather, the first by Zondagh, from a kick across from Albertijn, the second try was obtained by Albertijn himself. Van Schalkwijk made an unaccountable failure of the kick at goal from Zondagh's try. It was grounded beneath the bar. A Middlesex man was off the field when we gained these points.

After half-time our opponents were at full strength again. Steyn got a couple of tries, this latter half of the game; Daneel one, and Van Schalkwijk one, and one came from the forwards. Daneel kicked a goal on one occasion. Middlesex were really great tacklers and full of pluck; as usual they kept their tails up to the very end, not the bitter end, there is no "bitter end" for such sportsmen. As try succeeded try they simply played harder. The Guy's men have played better. Sprong was excellent, but there is not much wrong with a team that crosses the line seven times against such saving.

Guy's Team.—A. Van Niekerk, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, A. Daneel, E. L. Sprong, F. Bekker, W. D. Doherty, R. F. H. Duncan, W. H. Taylor, L. K. Watson, E. E. Neser, E. H. Fouraker, G. Zondagh, P. G. Harvey.

GUY'S v. RICHMOND.

The last home match took place on Saturday, February 18th, before a good crowd. Unfortunately the last few matches, coming so closely together, had weakened the Hospital somewhat. Duncan, Neser, Biddle, Bekker and Van Scalkwijk had to rest, through injuries and illness. Albertijn played, but he was damaged about the shoulder on the Thursday previous and therefore was not at concert pitch. It was good to see Graham-Davies in the field again. He was much in the picture on Saturday, the 18th, especially at first. But he is no good on the wing unless well fed and once or twice the ball should have been sent to him. Last year there was much hanging on by the centres in the cup-ties, when the wings should have been better and more frequently allowed the ball. The referee was very strict in this match against Richmond, both sides came under his whistle and free kicks were frequent. One of these Daneel turned to good account by goaling. Davies had some sprints down the touch line. Then some excellent passing saw Daneel away. He was tackled and passing went the other way. Steyn hung on with Davies unmarked. Soon after Steyn passed to Davies, who was stopped inches out only. More good handling, from a quick heel out and Steyn cleared the way beautifully for Zondagh to score. There was very little more of interest in the match. The game till half-time became a battle of the forwards, and after the interval very little open play followed. As far as Guy's were concerned Meacock failed to get the ball away to his backs. The forwards found the Richmond pack, with the Brothers Lawless. Mackay and Considine quite a hefty handful, and the whole side were just a bit stale. The tackling and defence was very fine indeed, while among the pack Doherty and Taylor were for ever leading the way. Fouraker was pulled up when dribbling away at full speed more than once. Why he was stopped no one knew; a scrum would be ordered and the good work recommenced. But neither side got far. We were rather fortunate not to get our line crossed, as several times the Richmond halves looked extremely dangerous. But something—a bad pass, a knock on, a faulty catch—ended the movement and no score followed. For Guy's I would commend the energy of Cookes, the fine play of Zondagh, the dash of Davies and the coolness of Van Niekerk.

Guy's 1 penalty goal 1 try (6 points), Richmond nil.

Guy's Team.—A. K. Van Niekerk, H. Graham-Davies, C. L. Steyn, P. K. Albertijn, A. Daneel, E. L. Sprong, S. P. Meacock, W. D. Doherty, W. H. Taylor, E. H. Fouraker, P. G. Harvey, G. Zondagh, L. K. Watson, F. J. Hutchinson, R. V. Cookes.

ASSOCIATION.

GUY'S v. LONDON.

(Second Round Inter-Hospital Cup.)

Played at Honor Oak Park on Wednesday, February 15th, and resulted in a win for Guy's by 4 goals to 1, scorers being Williams 2, Walters, Couch.

In the early stages play was of a very even character, and after Walters had scored with a brilliant shot from the wing, Williams equalised for London, directly from the restart. From now onwards Guy's were handicapped by an injury to Sennitt, who although pluckily continuing was never able to do more than limp for the rest of the game. London had more of the game from now to half-time and often looked like scoring, especially when they hit the cross-bar twice in quick succession.

After half-time a complete change came over the game and Guy's always had the game in hand after Williams scored from a good pass by Couch. The play of the forwards was brilliant and further goals were scored by Williams, and Couch from a centre by Morgan.

Guy's Team.—Hardy, Wakeford, Sennitt, Painter, O'Meara, Parry, Walters, Nicholls, Williams, Couch, Morgan.

GUY'S v. UNIVERSITY COLLEGE HOSPITAL.

(Semi-Final Inter-Hospital Cup.)

Played at Hale End on Wednesday, February 22nd, and resulted in an easy win for Guy's by 5 goals to love. Guy's lost the toss and had to play against the wind; in the first ten minutes our defence was shaky, but the U.C.H. forwards were unable to take two or three excellent chances. At the end of 15 minutes, after a beautiful combined movement, Couch scored. From now onwards Guy's dominated the play, especially in the second half. Two more goals were added before half-time by Walters and Williams; and after Nicholls scored, and their centre-half put the ball through his own goal when hard-pressed by Williams. But for an excellent display of goalkeeping the score must have been larger.

Guys have now qualified to meet Bart.'s in the final.

Guy's Team.—Hardy, Wakeford, Sennitt, Painter, O'Meara, Parry, Walters, Nicholls, Williams, Couch Morgan.

SECOND ELEVEN.

The Second Eleven have qualified to meet Bart.'s Second Eleven in the final of the Junior Cup by two good victories over London and University College Hospital. The former was played on London ground and was won 3—1; scorers being Nicolai (2) and James.

University College Hospital were beaten at Honor Oak Park by 4 goals to 1; scorers Cawn (2), James and Gonsalves.

Cross Country.

UNITED HOSPITALS HARE AND HOUNDS v. ORION HARRIERS.

On this occasion we were thoroughly beaten by the visitors by 17 points to 38. Our only excuse is that Housden was feeling too ill to run, but even he would not have affected the net result. The Orion Harriers paid us the compliment of sending down their first team; all of their men were thoroughly fit in view of the approaching Championships.

Their "star" man, A. H. Dare, set the pace across the Common with J. N. Ovington. At the first field Lightwood came to the front, followed by Jago and Faull, but they never overtook their opponents. Lightwood, who was not too fit, in spite of his success in the North of the Thames Championship a week earlier, was our first man home. Result:—

1. A. H. Dare (O.H.), 35 min. 17 sec.
2. J. N. Ovington (O.H.), 35 min. 35 sec.
3. J. A. Callum (O.H.), 35 min. 41 sec.
4. R. C. Lightwood (K.C.H.), 35 min. 47 sec.
5. C. E. Ovington (O.H.), 36 min. 1 sec.
6. W. J. Goffin (O.H.), 36 min. 11 sec.
7. M. E. M. Jago (Guy's), 36 min. 16 sec.
8. I. M. Walker (O.H.), 36 min. 56 sec.
9. J. L. Faull (Guy's), 37 min. 14 sec.
10. A. B. Forman (O.H.), 37 min. 22 sec.
11. N. L. Williams (O.H.), 37 min. 25 sec.
12. R. S. Chambers (Guy's), 37 min. 42 sec.
14. L. I. Hyder (K.C.H.), 38 min. 30 sec.
14. L. T. Hyder (K.C.H.), 38 min. 30 sec.
15. S. E. Theis (Guy's), 39 min. 2 sec.
16. W. W. Darley (Bart.'s), 39 min. 19 sec.
17. A. Simpson (K.C.H.), 42 min. 45 sec.
18. B. P. Atkinson (K.C.H.), 42 min. 45 sec.

The Race for the Kent-Hughes Cup takes place next Wednesday, March 8th. Housden or Lightwood should get first place. Unless any of our rivals have been hiding their "lights," we may expect Jago, Faull, and Chambers to occupy the next three places. Our fifth man is rather an uncertainty, and he will be the crux of the whole issue; for if he finishes low down he will add more points to our total than we can afford. Entries are unlimited, so that it clearly behoves any Guy's man who is not yet broken-winded to stagger round the course and hope for the best. The more we enter the more confident we can be of the result;—AND CONVERSELY. As the last 1½ miles is road, supporters on push-bikes will be very valuable.

Boxing.

The Annual Inter-Hospital Boxing Competitions will take place at 8 o'clock on March 7th, at the N.S.C., King's Hall, Covent Garden.

All Guy's men are invited to come and do their bit towards encouraging the Hospital Team. Guy's are the present holders of the Cup and lack of support may mean its loss.

Guy's Team—
Fly—A. Lewis.
Bantam—S. P. Meacock.
Feather—C. S. Gross.
Light—J. G. S. Thomas.
Welter—G. V. Lloyd-Williams.
Middle—H. Trafford.
Light Heavy—N. M. Holloway.
Heavy—R. F. H. Duncan.

G. V. LLOYD-WILLIAMS.
Hon. Sec. Guy's Hospital Boxing Club.

Fencing.

GUY'S v. HONOURABLE ARTILLERY COMPANY.

For the first time in ten years the Hospital has raised a fencing team sufficiently strong to issue and accept challenges, and on Tuesday, February 14th, the team visited the School of the H.A.C. for a match at Foils.

Our opponents won by 16 points to 9, but the score is not representative of the difference in fencing merit of the two teams, a fair number of the fights being decided by a 3 to 2 score. The H.A.C. were the stronger team, however, and deserved their win, but Guy's should be congratulated on putting up so good a show.

Of the team Foy and Housden both put up a series of useful fights, and with practice should help the strength of the team considerably. The former would do well to maintain a safer guard even after scoring an obvious hit, since the obvious is not always seen, and a delayed riposte may turn the tables in his opponent's favour. The latter should maintain the limits of the planche for it is easier to attack after a retirement in a straight line than from a diagonal line.

Spurrell, Silvester and Tom were being "blooded" to competition fighting, and, as is usual under such circumstances, discarded the advantage that instruction gives for more primitive methods of attack and defence.

Spurrell's show was very fair indeed for a beginner; Silvester has length which he will not, and stiffness which he should not, use, and Tom used slowness as a method of defence, his unintentionally stationary parry in carte most successfully worrying his opponents.

The team as a whole should cultivate a sound method of dealing with the unorthodox, take every advantage of an opening for a riposte, meet all bent-arm attacks with a quietly delivered coup temp and avoid defending by attack.

Our opponents extended a very generous hospitality and the return match fixed for March 13th, 6 o'clock at Guy's, is well anticipated.

Scores.—Foy, 5—0; Housden, 3—2; Spurrell, 1—4; Silvester, 0—5; Tom, 0—5. Total 9—16.

Notices.

It has been suggested that an association of Oxford Medical (Men) Students in London be started. In the past such an association existed and held very successful informal monthly dinners. It seems a pity that Oxford Medical Students should completely lose sight of each other on going down.

Would anyone who favours such a suggestion kindly communicate personally with one of the undersigned, so that a meeting may be arranged to discuss all details and to get the thing going.

(Signed) D. R. GAWLER.
E. B. STRAUSS.

Medical School,
King's College Hospital,
Denmark Hill, S.E. 5.
20th February, 1922.

The Metropolitan Asylums Board desire us to announce that Courses of Instruction in the Diagnosis and Treatment of Fevers will be begun in several of their hospitals in the first week in May. Full particulars may be obtained from the Medical School Office, or from the Clerk to the Metropolitan Asylums Board, Embankment, E.C.4.

Newcomen Street Day Nursery.

A Musical and Dancing Matinée is being held at the Aldwych Theatre on Friday, March 17th, by kind permission of Mr. Donald Calthrop, in aid of the Newcomen Street Day Nursery.

The following Dancing Schools and distinguished Artistes (by kind permission of their respective Managements) have already generously promised their services:

June and Mr. Clifton Webb, Mme. Kyasht and her School of Dancing, Miss Jean Sterling Mackinlay, Misquette and Maxly, The Trix Sisters and Miss Cone's School of Dancing, Miss Critchley's School of Dancing, The Mayfair School of Dancing and Miss Purcell's School of Dancing.

In connection with this an Amateur Valse and Fox Trot Competition is being arranged. Miss Vacani has very kindly lent her Dancing School, 159, Brompton Road at 6 p.m. on Thursdays, March 9th and 16th, for the semi-finals. Entrance Fee 10s. (5s. each competitor).

The final will be danced on the stage during the Matinée—the best 8 or 10 couples being left in to compete. For all particulars of the Matinée and entrance forms for Competition apply The Matinée Secretary, 19, Portland Place, W.1.

The Competition is arousing great interest and some beautiful prizes are being offered; it would greatly help towards the success of the Matinée if Guy's men would enter for the Dancing, and would do their best to make it known among those of their friends who are likely to be interested.

Specialities.

Messrs. LAGONDA, LIMITED, Staines. London Office:—195, Hammersmith Road, W.6.

The 11-h.p. Lagonda Car is put forward as the best car value on the market, and those who will closely examine and compare this Car with others at the same price, must be forced to the conclusion that this claim is justified.

It is of handsome design and upholstered throughout in the finest leather material, with heavily nickel plated fittings, and is entirely British made throughout.

The Lagonda Car is supplied as a two or four-seater, at the same price, £395.

The Two-seater Model is fitted with a luxurious Coupé body, which, with the hood down, forms a completely open Car.

The "All-Weather Model" is designed to carry four passengers, and is fitted with adjustable windscreen.

A special feature of the Car is that the Body and Chassis are constructed as a single unit, which gives a very light, but at the same time, rigid foundation, on which are mounted the power unit, transmission and axles.

The Engine is a 4-cylinder Monobloc, doing 35 miles to the gallon, with Overhead Inlet Valves, Camshaft and Magneto, driven by silent chain.

The 11-h.p. Lagonda has done well at Brooklands, and in every Official test of reliability and efficiency.

In the last London-Exeter-London Trial, four Lagondas entered and obtained four Gold Medals.

Many Medical Men are using this Car and speak very highly of it.

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ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

VOL. XXXVI., No. 879.] MARCH 18, 1922. [NINEPENCE.

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Passim.

WHEN reading the "Charivaria" in our national humorous weekly, we often feel that the gentleman who compiles that admirable page must have considerable difficulty in maintaining so high a standard of cheerful topical wit. One might visualise him carefully going through newspaper after newspaper in his search for items of news likely to provide entertainment (when properly handled), and marking the chosen passages with a blue pencil. Perhaps we are wrong. It may be that a succession of flashes of genius provides the paragraphs without effort on the part of the writer, or perhaps the whole affair is a combined effort representing the happy thoughts of many. The latter alternative seems unlikely, as the "Charivaria" bear the distinct impress of one individuality.

However that may be, it is certain that Editors often have recourse to a diligent search through the daily press, in the hope of thereby providing the wherewithal for leading articles.

It happened this week that the Editorial mind was fatigued by the somewhat parochial nature of recent paragraphs in "Passim." As our eyes scanned page after page of the material which daily provides the great British public with food for thought, they found little likely to prove of value for our purpose.

It was, perhaps, fortunate for our peace of mind that, after a summary rejection of the situation in India, the Rand strikes, and even the Lingfield races as unsuitable topics, we chanced upon an article published not long ago in an evening paper. It was an interesting article. Under the headline, BUMBLE TRYING IT ON OLIVER TWIST, the writer criticised the action of the Ministry of Health in sanctioning the performance of the Schick test upon workhouse children, and their immunisation to diphtheria, if found susceptible. Alarming statistics were given to prove that deaths frequently result from the use of the toxin-antitoxin (T.A.T.) with which immunisation is carried out, and, indeed, the idea that any such inoculations do confer immunity was scouted as one of the "familiar fictions" so often issued by medical men to account for their experiments. The following sentence is typical of the writer's attitude: "If there is a reaction to the injection, they say this shows the subject is liable to diphtheria—something like the older practice of throwing a person accused of witchcraft into the water. If she floated, she was a witch."

This opposition to the use of the Schick Reaction is apparently being engineered by

the National Anti-Vaccination League. We are reminded, by some of their arguments, of Mr. Bernard Shaw's preface on doctors, in the published form of his play, "The Doctor's Dilemma." In it we remember a passage which suggests that the action of the mammalian heart might have been studied by the use of the sphygmograph, rather than by the patient experiments of physiologists (whom he dubs cruel voluptuaries) upon the heart itself!

Our readers will remember the article on the Schick Reaction which we published on February 18th. The author clearly shows the value of the reaction in the diagnosis of diphtheria. At the same time he warns us that the preparation of the "toxin-antitoxin" mixture must be made by experts who realise the necessity of careful testing and accurate standardisation.

We should be the last to advocate the multiplication of compulsory inoculations. Life would become intolerable for the average man if he were to be beset at every turn by new rules and prophylactic regulations. But we do object to the wildly insufficient grounds upon which these anti-everything enthusiasts base their objections to every advance in medical science.

The fact remains that diphtheria is a disease which still takes its yearly toll of persons killed and disabled from the population of this country. We have a method whereby immunity may be conferred, and we have in the Schick Reaction a test as to whether a person is immune or no. As Dr. Eagleton says in his article, "Diphtheria is a preventable disease. If preventable, why not prevented?"

It is once again our sad task to record in these columns the death of one who has been associated with Guy's for many years. The death of Mrs. Wells, at one time a Sister at the Hospital and widow of the late Charles Henry Wells, a former Clerk to the Dean and to the Governors, occurred at South Norwood Park on March 13th, after a brief illness.

Our readers may remember that the Medical School will benefit substantially under the will of Mr. Wells, and under that of Mr. L. A. Dunn, the late Senior Surgeon to the Hospital. In the anticipation of considerable sums which they will eventually receive under these two bequests, the Medical School have undertaken the construction of new Anatomical and Biological Departments, and financial arrangements are now being made for an advance of capital, required for the purpose of adapting warehousing premises adjoining the School.

The fate of the old Anatomy Department, which was provided by the Hospital, is as yet undecided. It will probably be converted to the uses of the Children's Department, or perhaps of the V.D. Department, while the old Biological Department will form part of the Hospital Kitchen.

The new Anatomical Department will be one of the most up-to-date in the kingdom. The present buildings cannot adequately cope with the requirements of the large number of men now doing anatomy. No better use could be made of the legacies of these two benefactors of the School than the construction of a larger and a better-equipped department.

The vexed question of Clubs' Union subscriptions is again raised by our friend, "A Thirty-second Year Man," whose letter we publish on page 106. He is apparently labouring under the delusion that we advocate compulsory subscriptions, or so we gather from the tone of his letter, whereas the fact is that we are most definitely opposed to the idea, as we stated in our last issue. At the same time, we adhere to our expressed opinions of his com-

ments on the situation. To refrain from supporting one's Hospital Club, merely because somebody else may get more benefit from his subscription than one does oneself, seems to us to be so far removed from altruism, as to be almost blatantly self-seeking. His further suggestion, in this issue, that a non-playing member who pays his subscription, partly because he is aware of the good effect athletics have upon Hospital life, is thereby bribing the playing members to ensure good relations with his superiors and fellows, is too ridiculous to merit a serious retort.

One fact is obvious to all who take any interest in the affairs of the Clubs' Union, and that is that the catering in the College is very far from satisfactory. Very few people we have met can remember a time when there were not complaints, more or less bitter, as to these arrangements, so that this is no new grievance. It would appear from this that the trouble rests rather with the conditions under which the catering is undertaken, than with the efficiency or otherwise of any individual caterers.

We have reason to believe that a careful investigation of the situation as regards catering will be made very shortly. Is it too much to hope that this will be productive of improved conditions?

The past fortnight has been a very successful one for the Hospital in the field of sport. Not only has the Rugby Cup once more returned to us, but we have won the Inter-Hospital Boxing and Cross-Country Running. Accounts of these events will be found elsewhere in this issue. The Final of the Inter-Hospital Soccer still has to be decided. We have met St. Bart.'s twice, without either side being able to claim the victory. On both occasions the score was 2—2, in spite of the fact that extra time was played in the second match. In the first game we were lucky to avoid defeat; in the second it may be said that we deserved victory. The final Final should be a very exciting and sporting fixture. We hope all who can possibly do so will be present at the match which will take place on a date to be announced later. Support for the XI. may make all the difference between defeat and victory.

In the Inter-Hospital Boxing Competitions held at the N.S.C. on March 7th, the Guy's team proved the value of instruction at the hands of Alf. Hewitt. Of the seven men in the team, four were winners, and the other three runners up.

The Final Rugby Cup-tie has come and gone, with its usual accompaniment of cheerful ragging and general air of boisterous enjoyment. We do not know, at the time of going to press, what response those who collected money for the Hospital funds met with, but we trust that it was a generous one.

As regards the game itself, we can only say that by their decisive victory over the London Hospital, whom they defeated by 42—6, the Rugby XV. have established their position more firmly than ever, and that we offer them our sincere congratulations on thus winning the Cup for the third time in succession.

The presence of the King at Richmond intensified our pleasure in the success of our team. His Majesty's interest in Inter-Hospital Rugby is a source of great satisfaction to hospital men, and we feel that we are but expressing the views of the crowd which gave him such an ovation when we say that we are glad that he was able to present the Cup, once again, to the Guy's Captain.

Events of Interest for Fortnight ending April 1.

Mar. 20.—Clinical Lecture by Dr. Shipway on "Some Deaths during Anæsthesia."
†Prof. H. Roger (Dean of Medical Faculty, University of Paris) on "Les Fonctions du Poumon."

Mar. 21.—*Mr. Cecil Joll on "Tumours of the Thyroid Gland."

Mar. 22.—1.30 p.m., Clinical Lecture by Mr. Fagge on "Pleural Empyema."
Rugby, Guy's "B" v. St. John's College, Battersea (away).
7.45 p.m., Beggars Dance at Knightsbridge Hotel.

Mar. 23.—†Prof. A. Chauffard on "Syndrome Humoral de la Goutte."

Mar. 24.—*Dr. Wyard on "The Treatment of Inoperable Cancer."

Mar. 25.—Rugby, Guy's v. Swansea (away). Guy's "A" v. Old Blues "A" (away). Guy's Nomads v. G.W.R. Paddington (away).

Mar. 27.—Clinical Lecture by Dr. Cameron on "Vomiting in Infancy—Its Significance and Treatment."
†Prof. P. Duval on "Données actuelles de la Chirurgie Intra-Thoracique."

Mar. 28.—*Dr. Rice Oxley on "The Methods of Anæsthesia."

Mar. 29.—1.30 p.m., Clinical Lecture by Mr. Rowlands on "Acute Intestinal Obstruction."

Mar. 31.—Last Day of application for April ward appointments.

April 1.—Rugby, Guy's v. Northampton (away).
Oxford and Cambridge Boat Race.

Specialities.

The Treasure Cot Company, Ltd.

Attention is called to the fact that this Company has removed to larger and more accessible premises at No. 103, Oxford Street, London (nearly opposite Bourne and Hollingsworth). There are extensive showrooms on first and second floors and a beautiful display of articles dear to the heart of every mother, and suitable for baby and the nursery.

*Clinical Lecture at Cancer Hospital, Fulham Rd., at 4 p.m.

†French Lecture at Royal Society of Medicine (1, Wimpole Street), at 5 p.m.

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Guy's Hospital Missionary Society.

RECEIPTS AND PAYMENTS FOR THE YEAR ENDED DECEMBER 31st, 1921.

RECEIPTS.

1921.			£ s. d.
To Balance brought forward—			
Cash at Bank	29 4 10		
Petty Cash in Hand ...	0 15 4		
		30 0 2	
„ Subscriptions and Donations		24 12 0	
„ Interest (as per Post Office Book)...		2 0 7	
		£56 12 9	

PAYMENTS.

1921.			£ s. d.
By Subscriptions to other Funds	23 2 0		
„ Printing, Stationery, Magazines, &c.	3 12 10		
„ Postages	0 6 6		
		27 1 4	
„ Balance carried forward—			
Cash at Bank	28 9 5		
Petty Cash in Hand ...	1 2 0		
		29 11 5	
		£56 12 9	

Audited and found correct,
W. J. CURRY.
30th January, 1922.

Surgical Abstracts.

I.—Acute and Chronic Inflammation of the Pancreas.

SOURCES.

Treves and Keith.—Applied Anatomy.

Moynihan.—Abdominal Operations, Vol. II., p. 376 et seq.

Deaver.—Ann. Surgery, 68, 1918, p. 281; Surg. Gyn. and Obst., 1919, xxix., p. 497; Surg. Clin. N. America, Vol. I., No. 1., p. 1.

Bloodgood.—Trans. Am. Gastro-Ent. Ass., 1919, p. 180.

Gatewood.—Surg. Clin. Chicago, IV., 1920, p. 801.

MacKenzie-Wallis.—Q.J. Med., Oct., 1920.

Grey Turner.—Two articles in B. J. Surgery.

DEVELOPMENT.

Pancreas arises as outgrowth from foregut, developing from two buds:—

1. A dorsal, closely related to stomach. Forms duct of Santorini, and most of head body and tail.

2. A ventral, closely related to bile duct. Forms duct of Wirsung, but only part of head, and uncinate process.

PHYSIOLOGY.

Consists of two elements:—

1. *Islets of Langerhans*, more numerous in tail. They produce—

(a) A chalone, retarding glycogenolysis in liver.

(b) A hormone, facilitating use of glucose by tissues.

2. *Gland Tissue.*

Three main enzymes.—Trypsin; Steapsin; Amylopsin.

Secretion is alkaline ($NaHCO_3$). When poured out, corresponding increase in pH of blood, showing as diminished alveolar CO_2.

Stimulus to secretion is secretin.

Enzymes occur in the gland as inactive precursors, and are activated on reaching the duodenum by enterokinase. The precursors are also activated by bacteria (Deaver); leucocytes (Delezeune).

ANATOMY.

Pancreas lies on bodies of first and second lumbar vertebræ. Therefore surface marking is Addison's plane, same level as pylorus and pelvis of kidneys.

It is in relation to both sacs of peritoneum and to root of transverse mesocolon, but is *chiefly in lesser sac,* where it forms part of stomach bed. It is entirely retroperitoneal; therefore—

1. It is the most "silent" of organs.

2. It is rarely involved in visceroptoses, and is the only abdominal organ never described in an inguinal hernia.

Important Relations.—

1. Second stage of common bile duct is surrounded by tissue of head in 60 per cent of cases; may lie between head and duodenum, or deep to head.

2. Pylorus just above head.

3. Behind are aorta, inferior vena cava, crura of diaphragm, commencement of portal vein, both renal vessels.

Any of these may be involved in disease.

Ducts.—

1. Main duct of Wirsung; opens into second part of duodenum. In 70 per cent of cases, opens with common bile duct in ampulla of Vater; In 30 per cent opens separately. Duct runs in posterior part of gland. Ampulla is surrounded by plain muscle, (sphincter of Oddi).

2. Duct of Santorini; only present in 50 per cent of cases. Opens $\frac{3}{4}$ inch above Wirsung. May be a branch of Wirsung, or separate; may be the larger of the two.

Blood Supply.—

1. Superior Pancreatico-duodenal, from Gastro-duodenal.

2. Inferior Pancreatico-duodenal, from Superior Mesenteric.

3. Branches from Hepatic and Splenic artery. Rich anastomosis in gland, supported by little fibrous stroma. Sinusoids round islets.

Lymph Drainage.—Pancreas has no hilum. Lymphatics enter and leave it at various points like the blood vessels, and form a rich subperitoneal plexus on its surface. Lymphatics anastomose with those of the stomach, duodenum, spleen, liver, gall bladder, bile ducts, left suprarenal, and appendix. Communication is specially free with lymphatics of duodenum and gall bladder, and dye injected in either of these appears in lymphatics of pancreas.

PATHOLOGY.

A. *The pancreas may be infected*—

1. By blood stream, seen in scarlet fever and diphtheria.

2. By duct of Wirsung.

(a) Impaction of gall stone in ampulla.

(b) Sudden tension when sphincter is contracted.

3. By lymphatics.

B. *Infection in chronic pancreatitis.*—This is nearly always by lymphatics. (Deaver).

1. Usually associated with a primary focus, cholecystitis, gall stones, gastric or duodenal ulcer, appendix.

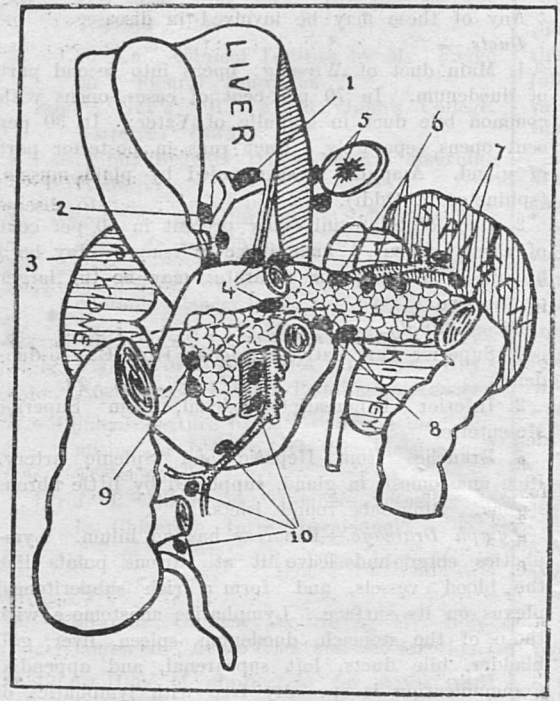
2. In early cases, change is chiefly in upper part of head (furthest from duct of Wirsung, nearest to source of infection) while main part of gland is normal.

3. In gall stones, lymphadenitis in gastro-hepatic omentum with a peripancreatic lymphadenitis are frequently seen by naked eye.

C. *Infection in acute pancreatitis.*

1. An ascending duct infection certainly occurs in some cases. It was the cause in an ultra-acute case recently in Naaman. It occurs in one case in seven according to White (Arch. Path. Inst. Lond. Hosp., Vol. I.)

Opie produced acute pancreatitis by injecting bile into the pancreatic duct in animals.



The pancreas and associated lymph-nodes (simplified from Deaver).

1. *Hepatic lymph glands.*
2. *Gall Bladder glands.*
3. *Common bile duct glands.*
4. *Inferior gastric.*
5. *Superior gastric.*
6. *Superior pancreatic.*
7. *Pancreatico splenic.*
8. *Inferior pancreatic.*
9. *Duodenal.*
10. *Appendicular.*

The glands in the transverse mesocolon and those on the aorta are not shown.

2. White believes duct infection is rare.
   (a) Because in acute pancreatitis, ducts nearly always present a normal appearance microscopically.
   (b) Because normal areas are usually found among hæmorrhagic areas. In an ascending duct infection, inflammation should be all over the gland.

3. Trypsinogen cannot be activated by bile. It can be activated by bacterial action, or by leucocytes. Therefore infection or hæmorrhage probably precede the acute changes. In the case of a duct infection, the process would be—
   (a) Bile acts as an irritant, producing hæmorrhage.
   (b) Liberation of leucocytes activates trypsinogen, giving rise to acute destructive changes.

D. *Chief effects in acute pancreatitis* are due to activation of pancreatic ferments in situ.

1. Steapsin—produces patches of fat necrosis.
2. Trypsin produces—
   (a) Rapid destruction of all neighbouring tissues.
   (b) Destruction of vessels, causing effusion of blood.
   (c) "Beef broth" peritoneal exudate in subacute cases, and putrid smell of still less acute ones.
   (d) Extreme shock. Due to toxic action of protein metabolites. ("Histamine shock.")

E. *Summary.*—Lymphatic infection from a neighbouring source of sepsis is the probable factor in all chronic pancreatitis, which is essentially an interstitial change. The primary agent in most cases of acute pancreatitis is also an infection by lymphatic channels, but in some it is a duct infection.

Acute Pancreatitis.

Incidence.—Said to occur chiefly in males, aged 30 to 50, inclined to fat, and with a previous history of indigestion. Statistics (Deaver) do not bear out the preponderance of males.

Types—

1. *Ultra-acute.*—(Mayo Robson) Hæmorrhage without inflammatory changes. Also called "pancreatic apoplexy." Extreme shock. Death in 48 hours.

2. *Acute Hæmorrhagic.*—Inflammatory changes precede hæmorrhage. Hæmorrhages multiple throughout gland. Fat necrosis; bloody exudate. Usually fatal, even though operated upon.

3. *Gangrenous.*—Destruction of gland not complete, and toxæmia not fatal. Followed by more or less extensive sloughs of pancreatic tissue. Later, if patient survives, abscesses in pancreas. May lead to:—

   General peritonitis.
   Abscess of lesser sac, or "false cyst of pancreas."
   Retroperitoneal abscess, pointing in either loin.
   Abscess in sub-diaphragmatic space.
   Perforation into stomach; duodenum; colon (with natural cure).

(N.B.—This subdivision is a purely artificial, if useful one. There is every intermediate stage between the three types.)

Clinical Picture—

1. *History.*—Very often previous history of jaundice and vague indigestion. Fifteen out of eighteen

operated on by Deaver, had gall stones. Onset is said to be as sudden and dramatic as anything in abdomen. Absolutely sudden agonising pain, which may often have been brought on by a jolt or quick movement.

2. *Pain.*—Is insupportable, but poorly localised. It is vaguely felt deep in epigastrium, mostly to left of mid line.

3. *Collapse* is immediate and extreme, and shows very little amelioration. The collapse of a perforation or strangulated viscus is due to a peritoneal reflex, and after 4 to 8 hours may pass off entirely, giving the "fools' paradise." That of acute pancreatitis persists.

4. *Vomiting* is usually present. It is insistent, but is never foul or fæculent till the onset of paralytic ileus.

5. *Hiccough.*—Frequent; of bad prognosis.

6. *Constipation* is generally obstinate, but flatus is passed, and an enema should give a result.

7. *Temperature.*—Is subnormal, rising slightly when peritonitis supervenes.

8. *Pulse.*—Feeble and rapid; that of shock. Blood pressure lowered. Pulse and blood pressure do not show a recovery, as they do in perforations and strangulations.

9. *Skin* is moist, cold and clammy.

10. *Abdomen.*—Rigidity is not at all a marked feature; when present, it is confined to the upper parts of the recti. In fact the most, characteristic thing is that in face of the history of a perforation, and the appearance and collapse of a perforation, the abdomen appears almost normal. Grey Turner points out that from the situation of the pancreas, rigidity would be expected to affect primarily the posterior abdominal muscles, and suggests that involvement of the crura of the diaphragm may account for the typical cyanosis.

11. *Tenderness* is most marked in the mid epigastric region. It may be in right iliac fossa (leakage down right paracolic gutter). When present in the left costo-vertebral angle, it is almost diagnostic.

12. *Lump.*—Is very rarely felt, except in the gangrenous cases.

13. *Cyanosis.*—All authors describe cyanosis of a yellowish colour, most marked over the abdomen.

14. *Blood count.*—Shows slight leucocytosis.

15. *Staining of abdominal wall.*—Grey Turner describes two cases of purpuric staining of the skin due to leakage of trypsin, in one instance along the falciform ligament, in the other into the loin.

(NOTE.—The above is the classical description of acute pancreatitis. From the observation of recent cases, however, it is very doubtful if the onset is as sudden, or the pain as agonising, as it is in cases of perforation. The patient in Naaman, an ultra acute case who died in 48 hours, tried to go to work after the first sharp pain. Cases of perforation never move from the place where the pain has felled them. Another suggestive thing is that, in the literature, cases were generally seen by the surgeon only after 24 to 48 hours; the dramatic onset of a perforation never allows this delay in calling in the surgeon. The most striking point is the absolute contrast between the history and extreme collapse on the one hand, and the almost complete absence of signs in the abdomen on the other.)

Diagnosis.—This is difficult, because of—

1. The rarity of acute pancreatitis.
2. The deep situation of the pancreas.
3. The absence of any one really typical symptom.
4. The frequence of a history pointing to disease of neighbouring organs.

Differential Diagnosis.—Acute pancreatitis is usually mistaken for one of the following conditions, in the order stated:—

1. High intestinal obstruction; because of the frequent vomiting and obstinate constipation coupled with the absence of the physical signs of peritonitis.
2. Perforation of a peptic ulcer; because of sudden onset and extreme collapse.
3. Perforated gall bladder; history suggesting perforation, and previous story of gall stones.
4. Perforated appendix.
5. Acute cholecystitis.
6. Mesenteric thrombosis.

Treatment is surgical. The operation will usually start as a laparotomy—

1. The presence of free blood in the peritoneum in a middle aged male giving a history of an upper abdominal catastrophe, is almost diagnostic. The only other possibilities are an acute volvulus, a mesenteric thrombosis, or, in a female, a ruptured ectopic gestation. Having found free blood, the omentum is immediately inspected for evidence of fat necrosis. In cases opened later, "beef broth" fluid is seen instead of blood.

2. The pancreas may be approached by several routes:—

(a) Through the gastro-hepatic omentum. This is the most direct route, and is bloodless. It is easy in many cases, especially where there is some visceroptosis. It is not ideal for drainage.

(b) Through the gastro-colic omentum. This is that usually adopted.

(c) Through the transverse mesocolon. Points in favour of this approach are that it gives free exposure and adequate drainage. Against, that it drains into the as yet uninfected infracolic compartment of the peritoneum, and that the neighbouring coils of jejunum are in contact with a tube which must remain in situation for some weeks,

and may be involved, early in pressure necrosis, later in adhesions.

(d) By a left lumbar incision. This is obviously the best route for drainage, but is chiefly applicable to cases of the gangrenous type, where a localised abscess has formed, and signs point to the left costo-vertebral angle. Disadvantages are the uncertainty of the diagnosis in most acute cases, and the inadequate exposure of the pancreas that is obtained.

3. The indications, in order of importance, are:—

(a) To provide a free outlet to the surface for trypsin and toxins.

(1) The peritoneum over the pancreas should be scarified. This serves the double purpose of relieving tension in the pancreas, and of preventing further retroperitoneal spread and further destruction. Miculicz stated that his mortality was reduced from about 100 per cent. to about 30 per cent. by this procedure. The pancreas may be gently explored with a blunt instrument, but sharp instruments or deep exploration carry a risk of causing grave hæmorrhage. It is almost impossible to control pancreatic hæmorrhage owing to the free anastomosis, and the absence of a stroma that will hold stitches.

(2) Drains should be inserted, into the lesser sac; into the right kidney pouch; into the left loin, right flank and pelvis (if considered necessary).

(b) To mop out all irritative fluid.

(c) If time permits, to treat the cause.

(1) Look for stones, especially in ampulla.

(2) Drain the gall bladder.

(3) If patient's condition justifies it, do a cholecystectomy and drain the common duct.

4. Post-operative treatment.

(a) The drain should remain in a long time, two to three weeks.

(b) The chief trouble is tryptic degestion of the track and skin. The latter requires protection with ointment.

(c) Persistent purulent discharge suggests a pancreatic slough, and is an indication for re-opening.

(d) The chief danger is secondary hæmorrhage from one of the larger vessels, splenic, superior mesenteric, etc.

Prognosis.—The death rate (Villar, Körte, Quenu, Mayo Robson) is about 60 per cent.

Chronic Pancreatitis.

Incidence.—Much the same as that of acute pancreatitis. 58 per cent are males. Age incidence, 30 to 50.

Types.—Two main types are described.

1. Interstitial, affecting chiefly the interlobular septa, and characterised by digestive disturbances.

2. Parenchymatous, affecting chiefly the islets, and characterised by glycosuria.

Chronic pancreatitis is, as stated above, nearly always secondary to disease of neighbouring viscera, especially the gall bladder, and infection is carried by way of the lymphatics. In 1,290 cases of chronic cholecystitis operated on at the Mayo Clinic, an associated pancreatitis was discovered in 347. Owing to this intimate association with gall stone disease, most writers discuss duct infection as a cause. In a few cases obstruction of the duct is found. Lymphatic infection is, however, the cause in the vast majority, because—

1. The early changes are always in the upper part of the head.

2. Pancreatitis is often seen with a cholecystitis that has not gone on to stone formation.

3. Judd says that in only 4 per cent of bodies are the ducts so arranged as to allow the regurgitation of bile.

4. According to Mann, the pressure in the common duct is rarely enough to cause regurgitation.

Accepting the view of a lymphatic infection, three stages are described:—

1. A chronic pancreatic lymphangitis.

2. A chronic interlobar pancreatitis.

3. A chronic interacinar pancreatitis.

Clinical Picture.—There is no definite syndrome of chronic pancreatitis. The symptoms are usually those of the associated lesion. The commonest symptoms, where gall stones are excluded, are:—

1. Recurrent attacks of severe pain in the epigastrium and at the right costal margin. Pain may be referred to the right shoulder, less often to the left shoulder or back, but referred pain is less common than in gall stone disease.

2. Jaundice. Not an important symptom. Usually due to an associated biliary lesion, but may be due to pressure of an enlarged head.

3. Flatulence.

4. Vomiting and retching.

5. "Indigestion" and colicky pains.

6. Glycosuria (in 7 per cent of cases).

7. Tenderness in epigastrium and right costal margin. Desjardin's "point pancreatique" is 2 inches above the umbilicus in the direction of the apex of the right axilla. Mayo Robson's point for pancreatic tenderness is 3 inches above the umbilicus. Neither is of much value.

8. The enlarged head is occasionally palpable in thin individuals or under anæsthesia.

Diagnosis.—Is made on the above signs, and the accessory tests mentioned below. Most cases are discovered in the course of operation. It is often impossible to tell a chronic pancreatitis from a car-

cinoma of the head. Excision of a piece for section is very dangerous, and quite unjustifiable.

Treatment.—The pancreas itself is out of the reach of legitimate surgery. The treatment, therefore, is that of the associated and causative lesion.

1. The stomach, duodenum, appendix, and pelvic organs should all be examined. Ulcers should be excised if possible.

2. The main thing is the gall bladder. Once infected it is always infected, and will not recover with simple drainage, even though it contains no stones.

3. Special search should be made for stones on the common bile and hepatic ducts.

4. If biliary obstruction is present, and is definitely pancreatic, prolonged drainage must be provided—

(a) By cholecystostomy.
(b) By cholecysto-duodenostomy or cholecysto-gastrostomy.
(c) By cholecystectomy and choledocho-duodenostomy.
(d) By cholecystectomy and a T tube in the common duct. Deaver states that one of his patients has worn a T tube for four years.

5. Archibald recommends division of the sphincter of Oddi, on the view that these cases are duct infections due to intractable spasm of the sphincter. The modern view of the pathology robs this procedure of its basis.

ACCESSORY TESTS.

1. *Lœwi's Test.*—One drop of 1/1000 adrenalin in the eye. If there is dilatation of the pupil in quarter of an hour, the result is positive. A positive result is obtained.

In nearly all cases of acute pancreatitis.
In about two-thirds of cases of chronic pancreatitis.
In about one-half of cases of diabetes.
In about one-quarter of cases of exophthalmic goitre.

2. *Pancreatic Diastase in the Urine.*—There is always some present *if the kidneys are efficient.* With efficient kidneys, the amount of diastase is increased in pancreatic obstruction, decreased in pancreatic insufficiency.

3. *Fæces.*—There is "steatorrhœa," the fæces being light in colour, foul, bulky, and acid (alkaline in biliary obstruction). They contain neutral fats and meat fibres.

4. *Glutoid capsules,* which are not digested in the stomach, are given, and their contents of meat or fat looked for in the fæces.

5. *Einhorn's Duodenal Tube.*—Direct duodenal samples may be taken. Not of much practical value.

6. *Cammidge's reaction.*—Writers seem to agree that this is no use.

7. *Glycosuria.*

SUMMARY.

The pancreas is the Clapham Junction of an upper abdominal lymph plexus, and suffers for the sins of any of its neighbours. It is rarely the culprit, but frequently the victim. It is not only an innocent, but also a remarkably silent sufferer, owing to its deep situation, and because its digestive functions can be largely taken over by other glands. It is not amenable to direct surgical treatment, since the absence of any hilum where the blood vessels can be controlled, and of a regular capsule or well developed fibrous stroma into which stitches may be inserted, make it almost impossible to control the hæmorrhage caused by interference; while any incision into its substance will liberate trypsinogen, which then becomes activated by the effused blood and starts an uncontrollable vicious circle. The treatment of disease of the pancreas is the treatment of the original offender, generally the gall bladder, next to this the duodenum or appendix. A diseased gall bladder should be excised wherever possible, as the mischief it may cause is not limited to the biliary apparatus.

The pathology of the organs contributing to the upper abdominal lymph plexus, the stomach, duodenum, pancreas, spleen, kidneys, transverse colon, and appendix, is intimately associated. Disease of one member is frequently accompanied by disease in another, and it by no means follows that the pathological process has originated, or is most advanced, in that organ which gives rise to the most *obvious symptoms. Therefore the surgical approach* to any one of them should be through an incision which will allow a careful examination of the whole group.

W. H. OGILVIE.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

When the "Gazette" was Young.

SIR,—As I have the Guy's GAZETTE (from Vol. 1 to Vol. 12, or, I should say, Number 1 to Number 12, printed together as one volume), now here before me, I think I might add a few notes with propriety. The Editor was a friend of mine, Mr. Cattell Jones, who, I believe, was of my year, 1868, or possibly the following year, 1869.

Personally I was a good deal associated with the Editor, together with others, in promoting the floating of the GAZETTE. C. J. worked very assiduously to float it, and we must admit he succeeded admirably.

The first number appeared on October 1st, 1872. It was always for the benefit of Guy's men, and more especially for "Original Communications,"

The volume brings back to my mind the days of my studentship and helped hugely to establish the *Esprit de Corps* amongst Guy's men. It certainly helped to establish that fine feeling of brotherhood which pertains to-day. Certainly it gave me my love for my noble profession and for sport.

Undoubtedly the fact of being a "Resident and in the Rooms" on three separate occasions as a Full Dresser was pleasant and most agreeable, also having been Clinical Assistant, both appointments materially enhancing my value as a G.P. in after life.

There are not many of us (Old 'Uns) left now, but I am quite certain that we all the older we get the more we venerate and revere good old Guy's.

I follow with the greatest gusto the rare doings of the Guy's Football Club and accord to them the title of the best club in the country and perhaps of the world,—I remain, yours faithfully,

W. H. SPURGIN.

Newcastle-on-Tyne.
March 7th, 1922.

Clubs' Union.

DEAR SIR,—Your remarks, re the Games Club, in your last issue call for more than a grunt of approval. Especially your suggestion that those non-members who do not join simply because they are dissatisfied should join and try to rectify matters. I should like to point out that those students who have been members in the past have done their best, especially with regard to the catering, but what notice has the Clubs' Union taken of it? We have tried many times to improve matters; meetings have been held, eloquent speeches have been made, but alas, all this has benefited us nothing—like the poor the A.B.C. remains with us. It has been said that the best way to appeal to a man is through the digestive system, but in this respect the Students' Club makes a very poor appeal. But if all the students joined and were determined, then we at last would have a "revolution" in the catering line.

In a Club such as ours the motto of it ought to be "Equal rights for all, special privileges for none," but is this the case? Many men join the Club and the only game they play is Rugby, they may not be brilliant players and may never dream of getting their place in the team. All they want is to be able to play for a team which has good fixtures and in which they can enjoy themselves. To do this away fixtures must be taken. The 1st team and "A" XV. are allowed to make as many away fixtures as they choose, but when it comes to the "B" and Nomads' XV.'s it is a different matter. The authorities look on and say "You must not accept fixtures in which the fare will be more than 2s. 6d., because we will have to pay," and so they are not allowed to accept fixtures with teams who they would very much like to play. Simply for this reason this to my mind is not a fair deal. We are all Guy's men and though we are not in the Hospital team and have no hopes of getting there, we do expect to have the same privileges as they do. By equal privileges we do not suggest that the two lower teams should make fixtures with teams the other side of England, or even travel as far as the 1st team or "A" XV., but these teams should be allowed to make fixtures at reasonable distances. I find I am by no means alone in my views on this point.

We know it is useless to write on the catering question, but in the other matter something can be done and ought to be done very quickly.

In closing may I point out to a "Thirty-Second Year Man," that to join the Club, even in the state it is in at the present time, is not merely a matter of joining while as a student, but that in doing so he joins for life and has some place to come to where he will feel at home, when he is stranded in this great unsociable London in years to come—and it may be better by then! A man must have a very tough hide indeed if he can in future years see his name appearing year after year in the "Directory of Guy's Men" not in black type,—Yours truly.

"A FAIR SPIN."

DEAR SIR,—May I ask "Surgeon-Commander, R.N." why being a student at Guy's should place one in identically the same position as a member of any service mess? He puts this statement forward without supporting it in any manner, and it is one of those statements whose very inaccuracy makes them difficult to disprove by writing. Were "Surgeon-Commander" to write to the GAZETTE and say that the War Memorial was made of gold I would not find it easy to prove that it was not. All I could say would be "It isn't, it's made of stone." And so all I can say in reply to his opening argument is that men at Guy's are not in the same position as members of a service mess. If they were, they would subscribe to the Clubs' Union.

Your correspondent goes on to say that it is deplorable to use Guy's as a sort of L.C.C. Continuation School. Very possibly, but that does not excuse the use of compulsion to increase the Clubs' Union funds. Queen Mary tried compulsion when she thought it deplorable that people should be Protestants, and everybody knows what *her* sobriquet was. "Surgeon-Commander's" final arguments seem to me to have no point at all; they are like the wisdom of God, which passeth understanding.

One last word with regard to "Surgeon-Commander's" letter. Halfway through is an allusion to

esprit de corps, and I beg to suggest that as many blunders are committed in the name of *esprit de corps* as are committed in the name of liberty.

Now let us turn to the comments in "Passim," on my letter which appeared in the last issue of the GAZETTE. In these comments it is stated that inter-hospital competitions increase good relations between hospitals and between the staff and the students at Guy's. This is very likely, but it leads to the obvious corollary that on this account non-playing students should, by paying the expenses, bribe the playing students to ensure these good relations for them. At this rate, it is the playing students who should dislike the idea of compulsion. Once again, no one should derive any benefit from the Clubs' Union unless he bears his proportion of the expense.

Next, "Passim" states that if a Guy's man is unwilling to contribute anything towards the prowess of Guy's, he is unworthy of the generations of sportsmen who preceded him. Well, one of these generations made special provision for these unworthy people by inserting various rules which admit a non-member occasionally to the College, and so on, while they do not breathe a word about compulsion. Again, it is very doubtful indeed if any Guy's man has "no pride at all" in the prowess of Guy's, and if so, he would be hardly likely to take pride in a club which wrung five guineas from him and gave him in return only what the majority of Clubs' Union members receive.

This brings us to the real point which "Passim" makes, when it says that many students do not subscribe to the Clubs' Union because they do not receive an adequate return for their money, and that the proper course to pursue is to improve the Club, not leave it. I have paid my subscription; may I offer in addition a few suggestions? Dare quam accipere.

First, let us have differential subscriptions, by which all who wish to play a game pay for that game, thus making every one sure that they are not paying for someone else's amusement, or (perish the thought!) that someone else is not paying for theirs. This system would have the additional merit of pointing out to the various committees the necessity of finding games for all their subscribers, and of seeing that they have an occasional home game, and so on. The non-player, of course, would only pay a subscription sufficient to cover the Collegiate part of the Union.

Secondly, let us have decent catering in the College. I know of several presentable restaurants (alas, barely within reach of Guy's) where a good three course table d'hôte lunch only costs two shillings. Why cannot the College, with a large clientèle ready at hand, do the same? Such an innovation would, of itself, largely increase the number of subscribers.

A THIRTY-SECOND YEAR MAN.

Out-Patients.

DEAR SIR,—I have recently sent two patients up to Out-Patients, who have been sent back, because they came at the wrong time.

I had told them the times as reported in the GAZETTE, for April, 30th, 1921. I do not remember a more recent time table than that, and that one does not state the times.

Might I suggest that another time table should be published, giving the times when new patients must be at the Hospital.

It would be a great help to general practitioners and save many patients a wasted journey.—I am, Yours faithfully,

G.-P.

[A list will be procured and published in our next issue.—Ed.]

Senior Dressers.

DEAR SIR,—Very soon the decree that each Full Surgeon shall have only six dressers will come into force. What work will be assigned to the men who are to be excluded from the senior dressership? We are told they will be doomed to another three months as junior dressers; it is difficult, however, to see how the Medical Council can expect the Junior Surgeon with his limited number of beds to accommodate more men than he does at present. Already now when the most fortunate of junior dressers has not more than three beds (and most have only two) it is bad enough, and signs of unhealthy bickering make their appearance, it is therefore very easy to picture the relations between dressers, when about 10 of them will have to share the work which should be done by three.

The decision of the Council, if carried into effect, will do much harm and *no* good, for it will send out many freshly qualified men to experiment on "an unsuspecting public" with experience scandalously inadequate. This will be the inevitable result, because the rejected man will lose not only the obtainable benefits derived from being a senior dresser, but also his chances of ever becoming a house officer. Who will suffer from this arrangement? The public, the doctor and the good name of Guy's. Some men may settle in sparsely populated parts of the world where emergency operations may have to be undertaken, and even those who will practice where better men are available may get many opportunities of making a mess of things.

The apparently inefficient student is the man who will be debarred from the senior dressership, but he is just the man who, most of all, urgently requires a further surgical appointment; the man with good ability is capable of picking up experience by watching only; it is the man with somewhat inferior learning powers, who requires more indi-

vidual teaching; unless he obtains the senior appointment, he will leave the hospital equipped with ability to do everything unsatisfactorily. From a moral point of view, his training dare not be rescinded. The new regulation will put hindrances in the way of those who need assistance most.

I am told that before the war there were only six senior dressers to the firm, but then the School was not so crowded as it is now, and each man undoubtedly obtained more experience in his junior appointments.

It is argued that at other hospitals men hold fewer surgical appointments, but that does not prove that they obtain as good a training. Besides, we are at Guy's because we decided that no other than a Guy's course would meet our needs. We do not want an imitation of methods of other schools.

Somebody suggested that the Council aims at preventing the apparently or obviously inefficient from ever qualifying, because examinations will, owing to lack of practical experience, become impossible for them. I do not even for a moment suspect such a motive. I am sure everyone realises that it is too late to exclude an undesirable man in his third or fourth year of study; he should have been excluded before admission; if he was not, it is the duty of the body that enabled him to register as a medical student to give him the maximum amount of instruction.

As students we do not understand why the intended step is considered necessary. Somebody must be overcrowded with assistants, and the senior surgeon, as he has more beds than anybody else, is the only one capable of standing it comfortably. Why try to shift the onus elsewhere?

It may be intended as a means of encouraging us to work harder, and offer the senior dressership as a bait, but this is quite unnecessary. The excellent attendance at optional lectures and at autopsies, the crowds who follow some surgeons and physicians on their teaching rounds, the overcrowded Out-patients' and many more facts prove that most men are keener than superficial observation leads one to imagine. It is therefore entirely wrong on the part of anyone to conclude that because a man fails to turn up where he is expected, that he is shirking work.

This letter is written not to criticise, but to express the opinion of many men who now hold junior appointments. I do not anticipate a change of mind on the part of the Medical Council, but I do hope that, at least a reason will be given to those who will be affected by the new regulation,—I am, sir, yours truly,

J. M. HURWITZ.

The College,
Guy's Hospital,
March 10th, 1922.

Landon Out-Patient Tea Fund.

STATEMENT OF INCOME AND EXPENDITURE
FOR THE YEAR ENDED FEBRUARY, 1922.

INCOME.			£ s. d.
To Donations and Collections—			
(as per List)			147 0 7
„ Interest on Invested Funds—			
5% Exchequer Bonds ...	7 0 0		
Deposit Interest	1 4 9		
		8 4 9	
			£155 5 4

EXPENDITURE.	£ s. d.
By Cost of Tea, Groceries, Provisions Fruit, etc.	27 19 9
„ Band	12 12 0
„ Gifts of Toys, Clothing, etc.	83 18 0
„ Police Fees, Gratuities, etc.	8 0 3
„ Printing, Stationery, Postage, etc. ...	6 12 11
„ Decorations, Flowers, etc.	6 3 3
„ Sundry Payments	0 17 4
	146 3 6
„ Excess of Income over Expenditure carried to Balance Sheet	9 1 10
	£155 5 4

BALANCE SHEET, FEBRUARY, 1922.

LIABILITIES.			£ s. d.
To Accumulated Funds—			
Balance brought forward from last Account			272 14 0
Plus—			
Excess of Income over Expenditure			9 1 10
			£281 15 10

ASSETS.			£ s. d.
By Investments—			
£200 5% Exchequer Bonds at cost ...			200 0 0
„ Cash at Bankers—			
On Deposit Account	45 0 0		
On Current Account	36 15 10		
		81 15 10	
			£281 15 10

Audited and found correct,
W. J. CURRY,
15th February, 1922.

F. A. SHELDON,
Treasurer,
Landon Tea Fund Committee,
Guy's Hospital Trained Nurses' Institution,
14, St. Thomas' Street, S.E.1.

The Use of the Ophthalmoscope in General Medical Wards.

CLINICAL LECTURE BY H. L. EASON, M.S., M.D.

GENTLEMEN,—I am going to address myself to-day more particularly to those who are in the Medical Wards or are about to enter them.

Ophthalmology is often felt to be rather a mystery, particularly, I think, on account of the appalling names with which nearly every ocular condition is labelled. In reality, however, eye work, except for its surgery, is very little of a specialism, and all those of you who are learning general medicine must know something of this particular subject.

The greater proportion of the work which we do in the Eye Department is testing for and prescribing spectacles. About 80 per cent. of our work consists of these cases; it is hardly medical at all, and is in private life done to a considerable extent by prescribing opticians in their various shops. A certain percentage of ophthalmic cases are external affections, such as conjunctivitis and similar diseases, due to infection by well-known organisms; and diseases of the eyelids and conjunctiva do not differ in essentials from ordinary skin lesions, only being modified to some extent on account of the moisture of the conjunctiva and lids. The staphylococcus albus is responsible for nearly all inflammatory conditions of the eyelids.

Finally, we have a certain amount of work in the investigation of conditions, that may or may not cause failure of sight, and that can only be seen by the ophthalmoscope, and it is about these conditions that I want to speak to you more particularly to-day.

Just as every student in the Medical Wards has a stethoscope, so he should possess an ophthalmoscope. It is a more expensive instrument, and more difficult to handle, but it should be used on every possible occasion, and I am going to try and give you some indication of the reason why you should do so.

Nearly all the diseases with which we are affected arise from an infection which we breathe in or absorb. The sentry at the usual gate of infection, the naso-pharynx, is the tonsil, and the laryngologist and the rhinologist usually see the early results of these bacillary attacks. With the ophthalmoscope we have the opportunity—to use a domestic metaphor—of looking in at the windows and seeing what is going on inside the house after the entry of the organism, and the particular interest of ophthalmoscopic work is that we have an opportunity of seeing diseases in actual progress during life.

For the most part in medicine and surgery we can only get an idea of what is happening inside the body—other than by post-mortem examination—by listening or by the sense of touch. With the ophthalmoscope we can see, under a considerable degree of magnification, what is happening in the vascular system of the body generally. It is because of this magnified view of a portion of the general vascular system that observations with the ophthalmoscope are so valuable. Therefore, I want you to think of the ophthalmoscope, not as an instrument for observing peculiar eye diseases with long names, but as a means of seeing what is taking place generally in the arteries and veins of the body, and also in the ends of the optic nerves, which are really an anterior prolongation of the central nervous system.

The vascular system in the eye is itself interesting. Acute vision is limited to a small portion of the retina—the yellow spot, or macula lutea. For the purpose of this acute vision it is essential that there should be no large arteries or veins running through the yellow spot, or in its immediate neighbourhood, but only a fine capillary network which will not cast a shadow. It is here, therefore, in the yellow spot, that there will first appear any indications of vascular disease, possibly earlier than they are observed elsewhere in the body.

As an example of a general infection, take the case of a single patch of choroiditis in one eye, a condition which is not unusual in early adult life, more particularly in young women. The patient may complain of mistiness in one eye; with an examination with the ophthalmoscope you will find in the retina an ill-defined, woolly, yellowish patch forming a striking contrast to the surrounding retina and choroid. In a few days the vitreous will become full of fine dust-like opacities, showing that much exudate is being thrown out from the patch into the vitreous. These fine vitreous opacities consist of leucocytes and fibrin, and as the lymph flows forward from the vitreous into the anterior chamber of the eye, so a day or two after

these opacities appear in the vitreous, little round masses of fibrin and leucocytes will be deposited on the posterior surface of the cornea, the condition being known as Keratitis Punctata. The term, however, is inaccurate. It is not an inflammation of the cornea (keratitis), it is merely a deposit on the back of the cornea. These deposits will ultimately become absorbed, and the process of inflammation will slowly subside, and, as everywhere else in the body, the exudate in the retina and choroid will become organised into fibrous tissue. The vascular layer of the choroid will become destroyed by the fibrous tissue, and there will remain only a white scar surrounded or partially covered by some proliferation of the ordinary retinal and choroidal pigment.

You might be satisfied with labelling this condition a single patch of choroiditis and leave it at that, but what I want you to consider is that the actual patch of choroiditis in itself is only of importance as indicating that somehow, from somewhere else in the body, a small infective plug has been carried by the blood stream, and has happened to get caught for a purely mechanical reason in the very fine capillary network in the choroidal vessels. Your immediate question should be, therefore, what is the nature of this infective plug, and where does it come from? And you will see at once that the problem is removed from the specialty of ophthalmology to the domain of general Medicine.

In any general infection of this sort in a young adult you are always suspicious of tuberculosis, and, as a matter of fact, many of these isolated patches of choroiditis are labelled tubercle. Unfortunately for us, but fortunately for the patient, these conditions hardly ever lead to the destruction of the eye, and there is, therefore, no opportunity of removing it for the purpose of making a section, or of a bacteriological examination. The actual cause of the infection is, therefore, in many cases only a matter of presumption, and the treatment of the patient will depend upon your general findings elsewhere. If there is no evidence of tubercle, you may have to consider other sources of infection, such as may arise from the naso-pharynx, the tonsil, the gums and teeth, or the general alimentary tract, and you should not be satisfied until you have exhausted every possible enquiry as to whence the patient has received an infection into the general blood stream.

Another disease, not bacillary, but protozoal, in which you may get a general infection through the blood stream, is syphilis, but the characteristic of syphilitic choroiditis is that the patches are seldom single, but nearly always numerous and widely scattered over the surrounding fundus. The multiplicity of the choroidal lesions is characteristic of the specific infection.

Here, again, your duty to the patient is not to consider him as suffering from choroiditis, but to say to yourself that here is a patient suffering from specific disease of which I happen to become aware locally in his eye. Your duty, therefore, is to treat him at once generally for his specific infection, as your local treatment, which at the best is very slight, will be of no use whatever to the patient.

I have spoken of tubercle before as a possible cause of choroiditis, and the most striking picture of ocular tubercle is that which is seen in cases of miliary tuberculosis. Just as tubercle in miliary tuberculosis is often carried from some focus, generally in the lungs, all over the body in the blood stream, to form miliary tubercle upon the meninges and peritoneum and in the organs of the body generally, so it appears in the eye as numerous circular white patches scattered over the retina and choroid, always in the immediate neighbourhood of the blood vessels, showing quite clearly the path by which the infection arrived. Miliary tubercle is practically the only form of choroiditis, excluding specific disease, in which you can always be certain as to the actual infection which causes the condition, for miliary tubercles are never seen in the choroid until the patient is at the point of death, usually from tuberculous meningitis, and there has been, therefore, ample opportunity to ascertain the cause in this particular instance.

But I want you to consider, throughout your professional career, that no inflammatory condition in the fundus should be left alone till you have exhausted every avenue of enquiry as to its cause. Most of them are extremely obscure, and you have a lifetime's work before you to elucidate the problems which are as yet unsolved.

Apart from the actual infections, the condition of the retina and choroid often gives the most valuable indication of early disease in the vascular system generally.

I have mentioned before that the choroid and retina in the immediate neighbourhood of the yellow spot contain no large vessels, but derive their blood supply from a very fine capillary network. It is evident, therefore, that in all conditions of arterial or venous degeneration or arterio-sclerosis, the disease would be apparent first in this area. There are, of course, other portions of the body where similar changes may be going on, and more particularly in the brain itself. But it is in the eye that you have the opportunity of seeing the processes in their very earliest stages, the ocular conditions giving you the first indication that such changes may be taking place elsewhere. It is quite common in old people to see the effects of arterial degeneration in the neighbourhood of the yellow spot long before the disease has become apparent elsewhere. The degeneration of the choroid, the thinning of the retina, proliferation of the retinal and choroidal pigment, may all be noticed in the macular region associated with a failure of vision in the central area only of the field of vision. This condition is so familiar to us in the Eye Department that it is known as senile degeneration of the macula, and we see scores of cases every year.

Apart from the fact that the patient's vision is failing, which is what concerns him most, this condition is of extreme interest to us in calling our attention to the fact that the patient's arteries are not so good as they used to be, and that if the retina is failing in this way, so also are his brain, his heart muscles, and his kidneys.

Albuminuric Retinitis is a clinical picture which is of never failing interest in the medical wards. If you are not already familiar with its appearances, you will shortly see cases with the characteristic hæmorrhages in the nerve fibre layer of the retina, most pronounced in the region of the yellow spot. Little woolly white patches of œdema in the nerve fibre layer of the retina and in later stages the glistening chalky white patches caused by the fibrosis of the earlier stages of the œdema. Here again I want you to remember that what is happening in the retina is also happening elsewhere in the body, though it may not as yet be apparent by any clinical signs. The presence of albuminuric retinitis is of very serious import with reference to the prognosis as to duration of life.

It is very difficult in a hospital practice to keep in touch with patients year after year, and it is only from well-kept records of private cases that any accurate deductions can be made.

Those of you who are interested in the subject could read the classical paper by the late Mr. Nettleship in the 15th volume of the Royal London Ophthalmic Hospital's Reports for 1913.

Of 42 cases of albuminuric retinitis in which Mr. Nettleship had information as to the duration of life after the incidence of retinitis, only 9, or just over one-fifth, lived more than two years, and no less than 25 died within the year. On the other hand albuminuric retinitis in pregnancy does not seem to be so serious. Of 22 cases of pregnancy retinitis noted by Mr. Nettleship, he only knew of five deaths, and only one of these occurred within two years of the retinitis. The four others died respectively $3\frac{1}{2}$, $4\frac{1}{4}$, 7, and 7 years after the retinitis. Six other cases, of whose death he had no record, are known to have lived more than two years; one of these at least five years, and one nine years. Others lived $5\frac{1}{2}$ years, 11 years, 10 years, 13, and 24 years.

It seems quite clear, therefore, that the albuminuric retinitis of pregnancy will not lead you to make such a serious prognosis as to the expectation of life as in those cases which are unassociated with pregnancy.

In diseases of the vascular system not only are there the classic pictures of albuminuric retinitis, but there are other characteristic appearances associated with arterio-sclerosis in late middle life.

Retinal arterio-sclerosis is indicated by an alteration in the appearance and sheen of the arteries, due to a thickening and degeneration of the middle coats of the arteries, giving rise to a characteristic appearance, which has been likened to a violin string covered with metal wire. The calibre of the arteries becomes irregular, the vessels in places being reduced to a mere thread, in others dilated and thickened. The rigid arteries, where they cross the veins, compress the vein and cause distention in the distal side, often with hæmorrhages through the vein wall.

All these symptoms may occur and be seen in the eye, before the patient shows signs of arterio-sclerosis elsewhere. The seriousness of

the condition is due to the fact that not only is the patient's vision affected, but that this arterio-sclerosis of the retinal arteries is nearly always associated with a similar condition of the cerebral arteries. Mr. Marcus Gunn, in a paper published some years ago, showed from statistics of his own patients that the great majority of patients suffering from this retinal condition died within six months from cerebral hæmorrhage.

In diabetes, again, you may find retinal hæmorrhages and a clinical appearance very much resembling that of albuminuric retinitis. In many cases the two conditions are indistinguishable from the retinal picture alone, but if there is any difference it is confined to the observation that in diabetic retinitis, the retinal hæmorrhages are sometimes in the deeper layers of the retina and are petechial and round in shape, in contrast to the hæmorrhages in albuminuric retinitis, which occur in the nerve fibre layer of the retina and are for that reason elongated, flame shaped, and striated.

One rare, but characteristic, ophthalmoscopic picture in diabetes should never be forgotten, viz., retinal lipæmia. In lipæmia associated with diabetes, the entire consistency and appearance of the blood is altered, owing to the presence of large quantities of protein substance, which was formerly supposed to be fat. The blood, instead of being dark red or purple, is of a light strawberry pink, and when the vessels are filled with blood of this consistency, the retina looks very pale, and the retinal vessels, instead of appearing darker than the surrounding fundus, appear lighter, and look quite pink and waxy. Lipæmia is a rare condition in diabetes, and as the condition is sometimes transient, it is not always observed.

Retinal hæmorrhages may also occur in grave anæmias. In pernicious anæmia there may be seen large, round petechial hæmorrhages scattered over the fundus oculi, and, as a rule, their size and shape are characteristic of the condition. But quite recently, in the medical wards, I have seen a case of severe chlorosis, *not* pernicious anæmia, in which there were numerous petechial hæmorrhages distributed over the retina, associated with a large sub-hyaloid hæmorrhage at the macula in each eye.

Space hardly permits me to do more than mention other characteristic ocular conditions associated with arterial and blood diseases, such as embolism of the central retinal artery, or thrombosis of the central retinal vein. The pictures of these conditions are available in every ophthalmic textbook, and they cannot be mistaken.

I should like to remind you of another important ophthalmoscopic appearance, of which probably you will see more than of any other condition in your time in the Medical Wards. I refer to optic neuritis, which, as you know, is one of the cardinal symptoms of cerebral tumour. There is no need to waste space here in giving a description of what is seen in optic neuritis, as pictures are far more valuable than verbal description, but I should like to call your attention to one or two interesting facts in connection with the association of optic neuritis with cerebral tumours. The classic paper on the subject is one by Mr. Leslie Paton, in the Transactions of the Ophthalmological Society of the United Kingdom for 1908, based on the clinical records of 252 cases. It had been stated some years ago by the late Sir Victor Horsley that the optic neuritis in a case of cerebral tumour was more pronounced, or of longer standing, in the eye on the side on which the cerebral tumour was located. The evidence adduced by Mr. Paton shows that there is no real support for this view, but his investigations bring out the interesting fact that the association of cerebral tumours with optic neuritis varies to a great extent with the actual position of the cerebral tumour. Of 41 cases of cerebellar tumour, all showed optic optic neuritis. All cases of tempero-sphenoidal tumour showed optic neuritis. In frontal and parietal tumours approximately 13 per cent. had no optic neuritis whatever. In sub-cortical tumours 38 per cent. had no optic neuritis, and in tumours of the optic thalamus and mid-brain, the optic neuritis was absent in 25 per cent. In tumours of the pons, over 43 per cent. of cases showed no optic neuritis.

You will see, therefore, that the absence of optic neuritis does not mean that there is not a cerebral tumour present, but in the absence of optic neuritis, if other symptoms point to the existence of a cerebral tumour, you are fairly safe in drawing the conclusion that the tumour is most likely to be in the pons, the mid-brain, or the sub-cortical region, and that it is extremely unlikely to be in the cerebellum or the tempero-sphenoidal lobe.

One or two other facts may be of interest in association with optic neuritis. Cerebral ab-

scesses, associated with middle ear disease, very often show no optic neuritis whatever, even though the abscess is situated in the tempero-sphenoidal lobe. And again, in cases of pituitary tumour, there may sometimes be no optic neuritis, but an optic atrophy, and the same remark is true of certain cases of internal hydrocephalus in adults.

In conclusion, may I express the hope that these few short remarks of mine may call your attention to the fact that there are very few conditions in the Medical Wards in which a regular and intelligent use of the ophthalmoscope may not add considerably to the interest of the case, and be of material assistance in arriving at a correct diagnosis.

Change of Address.

A. P. Marsh, L.D.S., 43, Wellington Square, Hastings.

Papers by Guy's Men.

F. J. Steward, F.R.C.S Case of Gall-Stones.—*Clinical Journal*, li. 1922, p. 97.

F. Bocquet Bull, L.R.C.P., M.R.C.S., L.R.C.S. The Immediate Torsion of Incisor Teeth.—*Dental Record*, xlii., 1922, p. 128.

H. W. Barber, M.D. (1) Lupus Erythematosus with Rheumatoid Arthritis. (2) Parakeratosis Variegata.—*Proc. Roy. Soc. Med., Sec. of Dermatology*, xv., 1922, p.21.

Montagu F. Hopson, L.D.S. A Maori Skull of Dental Interest.—*Ibid.*, Sec. of Odontology, p. 51.

Pass List.

Society of Apothecaries of London, February, 1922.

Forensic Medicine.

*S. Sedaros. J. Sullaimain.

*Has now completed the Examination.

Publications Received.

British Medical Journal, St. Bartholomew's Hospital Journal, St. Mary's Hospital Gazette, Nursing Times, Indian Medical Record, Abstracts of Bacteriology, The Queen's Medical Magazine (Birmingham), The Antiseptic (India), Medical Journal of South Africa, The Serpent (Manchester), Japan Medical World.

When the "Gazette" was Young.

(*Continued*).

Personally, I saw very little of Hilton as a surgeon. I was busy in the dissecting room during his last years and had, therefore, little interest and no business in the wards. But he left a glowing reputation behind him which filled the air of Guy's as the departed sun will often leave in the sky after it has set.

Sir William Gull.

For the same reason I saw but little of Sir William Gull in the wards. I may mention here that in these days a first year's man would not actually have been stopped, or in any mechanical way prevented from going round with the Senior Physicians and Surgeons, but all newly entered men in their first and second year, who desired to keep their good name, recognised that their place was in the Dissecting Room and Lecture Theatres, as the crowd around the beds was quite large enough of senior men without being swelled by men who ought to be reading Anatomy or learning the Pharmacopœia.

There were, however, some occasions when it was quite legitimate for me to hear what Sir William had to say on the subject of disease. One was a lecture on Typhoid. It was soon after the then Prince of Wales, afterwards Edward VII., had recovered from his attack, from which he made such a sensational recovery.

Sir William was not only a lecturer, he was an orator, and did not hesitate to employ the resources of dramatic art to impress a fact strongly upon his hearers. It is now more than fifty years since I heard this lecture, but its lessons and truths still remain with me. They have served me well and are as useful to-day as they were then. In some parts the charm of his delivery was so great that I can visualise him even now as he stands in the old Anatomical Theatre, lowering and raising his modulated voice with all the skill of a finished actor. He spoke of the necessity of the physician supervising the details of the nursing so closely, as to make him rather head nurse than a physician, otherwise he may sometimes lose the patient, as the nurse, perhaps, knowing the infectiousness of the excreta, may

somewhat clumsily push the bed-pan under the patient, making a bruise, which will degenerate into a bedsore and carry off a patient, who otherwise might have recovered. His manner and delivery were so impressive that I can recall his words verbatim, as he told us how he placed the bed-pan with his own hands gently and carefully under the buttocks of the Prince of Wales during that illness. "I remember, gentlemen," he said, "that a late distinguished patient said to me, 'You are doing that which it is beneath the dignity of a physician to do.' 'Sir,' I said, (here his voice sank to a deep solemn pitch, as he slowly bowed his head) 'I consider that *nothing* is beneath the dignity of a physician which conduces towards the recovery of his patient.'" Here he raised his body erect, and throwing out his arms, he continued in a loud commanding voice, "Kindness, gentlemen, is like God's blessed sunshine, it shineth alike in the palace and the privy and is thereby in no ways defiled." One of the most beautiful and apt similes I have ever heard. How still the theatre was, as the students heard the words one by one fall from his lips!

Addison.

When I have been speaking with Guy's men older than I am, on this subject they will hear of nobody being thought worthy of comparison with Addison as a lecturer, but as I never listened to Addison I am unable to speak with authority on this point.

Gull was a great teacher, too, at the bedside. He did not despise the usual routine and methods of Diagnosis, but he had naturally a highly developed instinct in recognising disease. The late Dr. Charles Hilton Fagge once told me that when he was a clerk in Gull's Clinical Wards, he would, in common with his other fellow clerks, often be at fault in diagnosing some fresh case, but when Gull came in the morning he unravelled their difficulties with such ease and readiness that they used to say he must have been in the night and examined the case.

Coming up "the Park" one day just as the House Physician met Sir William, I heard him say: "Oh, Sir William, I should like to hear your opinion on a case in 'Mary.' It is a case of Bright's disease; Will you see it?"

"With pleasure," Sir William said, and off they went upstairs to the top of the new Medical Wards (the lower portion of Hunt's House nearest Newcomen Street, the other half was not yet built). "It will be worth my while to go, too," I said. So at last we arrived in the ward. The H.P. stood beside a bed near the door. "This is the case, Sir William," he said. Gull looked at him, remarking, "You said Bright's Disease!" "Yes," said the H.P. "This is he." "Oh, nonsense," quickly retorted Sir William. "This is a boy; Bright's is an old man's disease, impossible in boys." I never forgot this lesson.

Dr. Wilks.

How Wilks, the idol of the medical side, used to try and hammer into us the fact that Bright's Disease is not a disease of the kidney, and ought not to be spoken of in connection with the kidney. It is a degeneration of tissue throughout the body generally, but first manifesting its presence in the kidney by allowing to pass through the renal walls, albumen, which may be demonstrated over and over again. Some years after he once remarked very sadly, "All my teaching has been of no use, men up at the College still talk of Bright's being a disease of the kidneys, and I have to pass it, for I find that it is so described now in the text-books on medicine. So I suppose I must myself now teach it too." Wilks was a great admirer of Bright as a sound physician and pathologist. I remember him once coming into the theatre at 3 p.m. to deliver his lecture on medicine. His long white hair was ruffled and he looked very unsettled. "I have just come down from the College," he began, "where I have been examining students. Why will men still talk of 'splashing' as one of the physical signs of pleuritic effusion? If I thought, gentlemen, that you would remember it I would repeat nothing else for the next hour but dulness on percussion, no tactile vibration, and no vocal fremitus. Do not, if you please, talk of splashing." Valvular disease of the heart and the employment of digitalis was another subject on which he used to dwell, and beg of men not to consider that valvular disease of the heart automatically demanded foxglove.

He would hold out the palms of his hands like the two pans of a pair of scales as he urged the necessity of dividing all heart cases into two classes; one in which digitalis gave relief to all the symptoms, the other in which it was contra-indicated and productive only of harm.

"Do try and remember," he would say, "these two classes first of all, and then proceed onward to other details, but it is imperative that you make a clear and definite distinction and divide the two classes and recognise the condition. If you will only do this and nothing more you will have gained a trustworthy guide in the treatment of cardiac dyspnœa. Here is a case in point, you see how he is labouring to get his breath. Give him digitalis and come and look at him to-morrow; his breathing will be quiet and regular. Do, gentlemen, I beg of you, remember these two classes."

He was an excellent teacher of medicine and much loved by the students. He seemed to take a personal interest in his clerks and taught in such a friendly manner. I remember how one of his clerks, Henry Ashly, later of Manchester, took much pains to extract a pellet of lead from the urine of a patient suffering from plumbism. This was very pleasing to Wilks, how he used to hold it in his fingers as he impressed on us the necessity of proving our diagnoses and not being satisfied with indefinite conclusions, but to leave no stone unturned until we had dragged the object sought for into the light of objective demonstration, if possible.

(A few years after leaving Guy's, being in the neighbourhood at a time when I knew Wilks would be in the wards, I joined the group of students going round with him. When he recognised me he eagerly asked, "What is the profession talking about in the country now? Do patients come to you and ask you to give them phosphorus?" "No," I answered. "They do, to me," he said, "and I give it them. It is cruel to crush their belief that they have at last found a remedy for what they have been told is incurable. The wife of a surgeon," he went on to say, "recently came to me and said 'Dr. Wilks you have told me that I am suffering from cancer, and my husband tells me the same thing, and you both say that it is incurable. I have come to tell you that I have been to a herbalist, and he tells me that he can cure me and I am going to try and believe it.' "And I don't blame her," said Wilks. "If I had an incurable disease and I knew I had, and someone said to me 'Swallow this, it will cure you,' I should swallow it and try and believe that it would." This little anecdote is very characteristic of Wilks, especially when garnished with his appropriate gestures. He had a singular gift of making his teaching interesting. He was the last man to present you with a bundle of dry facts and stubborn truths. He was a master in offering it, not as a bag of flour and sugar and crude indigestible nutriment, but in preparing it, by his skill in words and phraseology, into appetising little cakes which were readily absorbed and remembered.)

Dr. Owen Rees.

"There is no homœopathy in surgery," said Owen Rees once, his fellow lecturer on Medicine, when he saw an operation on one of Wilks' cases cured by division of a constricting fibrous band. Let me say that this was a wonderful thing in these days, both as to accuracy of diagnosis, as well as skilful surgery, before our knowledge of asepsis had made the interior of the abdomen as familiar to us during life as it is now. Surgeons then operated in the dirtiest, blood and pus stained coat they had got, and washed their hands *after* the operation, not *before*. A successful laparotomy was a thing to be proud of under such conditions. Now we wonder at our blindness.

Dr. Owen Rees had one peculiarity which marked his lectures. We were always sure of one dry crusted joke. It might be even a pun, but the wit was always good. Except on one occasion not a muscle of his face betrayed where the joke lay, but as we were always on the lookout for it, he had the gratification of knowing it was not wasted. The one occasion to which I refer he paused slightly, as usual, to make room for the hum of appreciation which greeted his sally. There was a deep silence only. We had not noticed the joke. He did not proceed, but leaned on the long pointer, which he grasped, and looked solemnly before him at the benches. We knew what it indicated, and simultaneously each one dug out the joke for himself and a loud murmur of approbation told the tale. He smiled and proceeded with his lecture. It is the only instance I ever saw of him smiling at, or noticing, his own wit.

Alfred Swayne Taylor.

Another lecturer of the period which marked the birth of the Gazette was Alfred Swayne Taylor on Medical Jurisprudence. I was always deeply interested. He was a powerful

lecturer, and spoke with such clearness and accuracy that there was no difficulty in remembering his plain truths. How different to some whose sentences were so involved and delivery so halting that it was impossible to keep the thread unbroken long.

THE DISSECTING ROOM.

Pye-Smith and Howse were then demonstrators of anatomy, and excellent they were. I never knew either of them ever at a standstill or failing to call to mind any recondite anatomical fact. It was Howse who conceived the idea of injecting the vessels with glycerine. I think it was only tried on one cadaver. I had an "upper" on it in October, 1869. The vessels were not filled with carmine. How moist the parts kept. It was quite a treat to dissect it. There was no dryness or shrivelling. Everything remained distinct and clear. I do not know why it was not continued, probably on account of its expense, as it took a large quantity of glycerine. Many came to see it, and I can strongly recommend it to any interested in dissecting specimens for comparative anatomy.

JIM HAINSBY.

Another original and striking satellite of the dissecting room was Jim Hainsby, the man who prepared the bodies. He was short and had only one leg. His face was so completely covered with acne, that it shone brilliantly like one deep crimson patch. He wore always a frock coat and silk hat, all of which were so shiny and greasy looking that it was rumoured he polished them with fat. His voice was raucous, but markedly polite. His "Sir" was always uttered with emphasis and pause. It was unwise to try and make jokes at the expense of Jim, or in any way make him a target for cheap wit. On such rare occasions when a man was inexperienced and foolhardy enough to attempt it, he would be the recipient of such a vocabulary of abuse as was always sufficient to prevent a second attempt. At its conclusion Jim would turn to some older acquaintance and remark in an impressive manner, "When people speak like a gentleman to me, I speak like a gentleman to them, but I can talk as well as they can." Another thing that used to call forth, in a subdued form, Jim's other "talk" was when he was collecting the defunct osteology of a "finished" subject. As he roamed among the tables looking for carpus and tarsus and even radius and ulna, holding in one hand the incomplete member, a deaf man could have gleaned from his inflamed rubicund visage, the disjointed adjectives he sullenly dropped in a low muttering voice round about the men who had been at work on the "parts" he was searching. It was "talk" that would not bear utterance in a promiscuous assembly, composed partly of demonstrators.

LECTURES.

Attendance at 9 o'clock anatomy lecture was the most irksome job on the day's programme, and I do not think much stress was really laid on its due performance. I was certainly guilty of skipping the majority. The still hours of the night was always to me the time when I could read best, and going to bed at 2 a.m. or after was not the way to rise in the cold dark mornings at 8 or sooner and catch the 8.40 train to London Bridge. I never knew a case of a man having been refused "signing up" if he worked well in the dissecting room. However Steen, the janitor, kept his list at all was a great puzzle to us, for he stood listlessly at the door of the theatre without any notebook or pencil and seemed to take only the most casual interest in the one hundred and fifty men pushing past him to the benches. I know, however, on the best possible authority, of one instance where the powers refused time after time to sign a man up for his first College, even though his attendance at lectures was regular and frequent. At length his father saw the demonstrators and lecturer and asked on what grounds they denied him his paper. "Because of his ignorance of anatomy; he is certain not to pass." His father insisted on him being allowed to try at any rate. "We will sign him up, if you insist upon it, but if he fails we shall take his name off the hospital list, as he will lower our average, which just now is too good to be marred by *certain* failures." His father insisted, the son was ploughed, and —expelled. The man read in a desultory, unmethodical way, but he lacked natural ability as well as industry, and was markedly unfitted for the profession.

(To be continued).

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Reviews.

Intrinsic Cancer of the Larynx and the Operation of Laryngo-fissure. By Irwin Moore, M.B., C.M.Edin., Surgeon to the Hospital for Diseases of the Throat, Golden Square, W. Pages ix. and 147, with 46 original illustrations. (University of London Press.) Price 20s. net.

It is interesting to a Guy's man opening this book to read "The first great exponent of this operation was Arthur Durham (*as long ago as* 1872), and if his advice and experience had been followed in place of the condemnatory opinions of Burns, Bilhoth and Morell Mackenzie, this operation would not have fallen into such complete abeyance and discredit until revised by Butlin and Semon in 1890."

We can well imagine some saying that the Specialists are again running away with themselves, in wanting a whole book on a single operation, but in this case we believe there is a justification. The disease for which the operation is done is a rare one, two cases only of intrinsic carcinoma of the larynx have occurred in one of the Guy's Clinics in five years, and one only of these has been suitable for operation. Therefore no one, unless he gets very special opportunities of collecting many cases from a large area will ever have the opportunity of doing many cases. But when the case is found we have a condition in which the knife is fitted to deal with the disease of cancer to an extent that it is not so fitted in any other part of the body. If it is possible ever to tell a patient that he is safe from recurrence from this disease it is so when the operation of laryngo-fissure has been performed. And we can be able to feel hope in our own minds in as many months as it is necessary to wait years in cases of cancer of other parts, such as the tongue. When three months have passed without recurrence the laryngologist can feel as confident as he can in three years after an operation for cancer of the breast, and when a year is passed he can speak with the same confidence to his patient as the general-surgeon can in the other case in five years.

We see then that the laryngologist doing this operation will find it necessary to read it up each time that he has to do it. The operation is no difficult one in itself, but it is one that may very easily lead to pneumonia, and it is therefore one which depends for its success, not upon any inherent difficulties in digital manipulations, but upon careful attention to numerous details, which may be varied in form, but to which adherence must be kept in principle. It is then a matter of great convenience to have such a detailed account of every stage of this operation, and we would advise every laryngologist who sets out to do this for the first few times to make himself thoroughly at home with the operation for sub-mucous resection of the septum nasi, to go and see someone else perform this operation on more than one occasion, to buy or borrow certain very special instruments which have been devised for the operation, and to procure and study Dr. Irwin Moore's book. It is clearly written, clearly printed, and well arranged with an excellent series of simple pictures illustrating the various stages at the operation. As this is essentially a specialist's operation we do not advise any general surgeon to buy this book. Laryngologists will all need it, but even then we do not suppose Dr. Irwin Moore will see much of the high price that must be paid for it. Indeed, we suspect, from the Preface, that this is a cheaper way of losing money than by providing copies of reprints of the articles which Dr. Moore wrote for the "Journal of Laryngology and Otology."

In conclusion we are pleased to note that this is an operation that has been developed to its present stage entirely by British surgeons practising in London.

Football.

GUY'S v. BART.'S.

(Semi-Final Round. Senior Inter-Hospital Cup-Tie.)

A fine day at Richmond on March 2nd, and a good crowd gathered to witness this match, looked forward to as the most strenuous in our passage to the Final. Ill luck dogged Bart.'s, as C. S. Shaw and Parker could not turn out for them. This was most unfortunate as both are forwards of outstanding merit, and excellent as Carnegie-Brown and Allen were, the absence of the former pair was much felt by our opponents.

Guy's had the advantage of a strong diagonal wind to start with, but it was the other team that showed up most prominently at first, for some 10 to 15 minutes they played really good Rugby, packing low and pushing hard. Their threequarters too got some service of the ball. Here they failed somewhat, though Moody-Jones and Neville, the two wing men, got going more than once. Gradually Guy's got more together and some good use being made of the powerful wind, a firm footing was established in Bart.'s territory. Almost the first time the ball was successfully heeled to our side, Bekker sent out a low pass. Sprong picked it up in some extraordinary way and Daneel received at top speed. With about 20 yards to go Daneel went like a thunderbolt to score wide from the posts. It was a fine try—Neser was a little wide with his kick. The play now came our way and Albertijn showed much cleverness. A cross-kick from him, saw Fouraker field and score though thrown by Gaisford, the Bart.'s back. Daneel cleverly converted. The activity of Neser was very apparent this first half. He was ever on the ball and his

appearance wherever needed, proved once again how well he fills the position of general handyman. L. K. Watson, after much inter-handling by the forwards, was the next to score. Daneel's excellent kick this time hit the post. A shot at goal for offside brought no good result and an effort by Steyn in midfield was bottled up, the ball coming much too slowly for the winger to have a chance. Interspersed between our tries was a very fine run by Neville, the Bart.'s left wing. Van Niekerk, who had had little to do, stopped him, aided by the threes', whose speed got them back to help. At half-time we led by 11 points to nil.

Doherty's leadership this second half was indeed pronounced. In every melée and ever on the ball, both by example and preceipt he kept his forwards to the task and right well they responded. Completely dominating the scrums, our friends the enemy were often pushed yards. Taylor played grandly. Duncan was at his best, and once when going at full pace with almost an opening just ahead, he was apparently rather badly impeded. The other forwards were all as good though not so much in the picture, Zondagh doing his job thoroughly. It was a solid eight working as one man. The backs could not complain of lack of chances. Several times a score looked certain, but the tackling was severe and Van Schalkwijk was off colour, and could not give or take passes. Steyn had no help till Albertijn sent out a pass about which Steyn made no mistake. A try was gained, but no conversion followed. Albertijn next cross kicked, but the forwards were not able to reach it, ere Gaisford fielded and sent down field. Soon we were back and Daneel again shot over the line to score a try which Neser failed, in the heavy breeze, to convert. Bekker played magnificently and Sprong was very good, though occasionally standing at the moment of sending on his pass. Some of his work, though, was clever and most elusive. Van Niekerk's task was an easy one. Albertijn's afternoon was filled with a great display of centre threequarter play. I would like to add a word of praise for Gaisford, the Bart.'s back. The last two years Smuts, in this position, showed us some wonderful tackling and kicking. Gaisford seems a very worthy successor to him.

Result.—Guy's 1 goal 4 tries (17 points), Bart.'s nil.

Referee—Mr. T. H. Vile (Welsh International).

Guy's Team.—A. K. Van Niekerk, A. Daneel, P. K. Albertijn, J. G. Van Schalkwijk, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, W. H. Taylor, E. H. Fouraker, L. K. Watson, E. E. Neser, P. G. Zondagh, P. G. Harvey.

GUY'S NOMADS v. HARPENDEN.

This match was played at Honor Oak Park on March 4th, in a sea of mud. To make the ground worse there was heavy rain just before the match started. It was entirely a forwards' game—the ball being very greasy for the threequarters to handle.

In the first half the Harpenden forwards got the ball almost every time, but our forwards got it out pretty well in the second half. At half-time there was no score. Weston got over from a scrum near the Harpenden line, but unfortunately was offside.

Within the last quarter of an hour Tupping scored following up a loose kick. Worthington, at flying half made one or two useful openings. Ettles, Mill and Strong were always noticeable in the forwards.

Result—Guy's Nomads 1 try, Harpenden nil.

Guy's Team.—Hushi, Tupping, Newbury, Hopson, Jones, Cohen, Weston, Worthington, Strong, J. Tregarthen, Mill, Ettles, Jowell, Garland, Teis.

Fencing.

GUY'S v. HONOURABLE ARTILLERY COMPANY.

The return match was decided on the evening of March 13th, in the Pavy Gym., Guy's again losing to the visitors, but this time by the narrow margin of one decision only. The score being 13 to 12 against.

Guy's team wish to thank a very generous audience for their approval of the fighting, a courtesy which was fully appreciated by our opponents. The teams were nearly as before Captain Johnston playing in place of Major Wright for the H.A.C. and C. H. Johnson answering for W. R. Spurrell of Guy's who had injured his sword hand.

Previous criticism still holds good. There is no better method of dealing with impetuous attack than an equally impetuous retirement, and a good lunge, well delivered, is better than a series of shortened sword play at an opponent who rushes well within sword length distance. He creates the disadvantage to his own cost and since such attacks are invariably accomplished with a bent sword-arm a coup temp will secure the easiest of hits and keep an opponent wondering considerably as to his own failure, a much desired frame of mind in which to place him.

Tom, although decidedly unwell, assisted the team and showed improvement on his last display. Johnson was new and showed much better style when not faced with problems of attack requiring immediate decision. This he will remedy with experience and all considered he did well.

Silvester was better, but with six feet of body plus an arm and a foil he should have kept off the most D'Artagnanesque attack with ease and grace. Housden lost two fights only and in each of these the margin was narrow enough to consider the fights at least equal. He maintained the planche but too many attacks finished with the flat of the blade laid on, the point having well missed his op

ponent. His point well directed to the target might have brought him five victories, but the error of direction was not always his, since in at least two cases his opponents found difficulty in maintaining the planche. Foy still lowers his point after scoring. Some schools of style approve of this, but in competitive work it is a consideration that will bring disaster with judges who are not quite au fait with Amateur Fencing Association Rules. However he was successful in his fights, which gives confidence to a safer display in future matches.

A final criticism.—Remember a straight arm a straight foil and a *straight right foot* are essential for a true hit and when these are accompanied by an appreciation of the exact moment, a score in favour is a tolerable certainty.

The evening was successful in every way, and it is hoped that further matches will be arranged before the gym. season closes for the year.

Scores:—Foy 5—0; Housden 3—2; Silvester 2—3; Johnson 2—3; Tom 0—5. Total, 12—13.

Athletic Club.

The Annual General Meeting of this Club was held on Monday, March 13th. Dr. Fawcett was in the chair.

The following Officers were elected for the year 1922—1923:—

President—Dr. Fawcett.

Hon. Treasurer—W. K. Fry, Esq.

Hon. Secretaries—S. V. Strong, A. S. Gough.

Committee—S. E. Theis, T. M. Robb, M. E. M. Jago, J. C. T. Tregarthen, C. L. Steyn, H. J. Fuller, K. O. Parsons, C. W. Greenway, S. S. Sugman, A. H. Shelswell, L. K. Watson.

The Secretary announced that the Hospital Sports would be held at Honor Oak Park on Wednesday, May 31st.

Hockey.

GUY'S v. BALLIOL.

This match, played on Tuesday, February 28th, at Oxford, resulted in a win for Balliol by 7 goals to 4.

The game was more even than the score suggests, and had Reynolds at goal shown anything like his usual form the Hospital might have won.

Our forwards were better together than on any occasion this season, Schollum and Parkinson being especially good.

Bonnalie and Gathergood were very steady at back.

Considering that Balliol had four Blues playing it was a good performance.

Boxing.

The Annual Inter-Hospital Boxing Competitions took place at the N.S.C. on Tuesday, 7th March. Guy's came out an easy first, every man in the team reaching his respective final. The standard of boxing shown was a high one, and the result was a personal triumph for the Guy's trainer, Alf. Hewitt, who, by the way, was as much in the picture as a second as usual.

Results—

Flyweight—

I.—V. Barhim (Bart.'s) beat G. Israelstan (Middlesex) on points.

II.—D. Plum (St. Thomas's) beat S. A. Romain (London) on points.

Final.—Plum, who showed himself to be a clever boxer, won the final fairly easily.

Bantamweight—

I.—S. P. Meacock (Guy's) beat S. B. Benton (Bart.'s).

After an even first round, Meacock landed a somewhat lucky right to the jaw, and the fight was stopped in his favour in the second round.

II.—A. Kodkin (Middlesex) knocked out J. J. Robinson (St. Thomas's) in the second round.

Final.—A. Kodkin (Middlesex) beat S. P. Meacock (Guy's) on points.

The first two rounds were very even, but in the third Meacock was cautioned for hitting low. This appeared to upset him for he started to mix it. These tactics just suited Kodkin, who is naturally a two-handed fighter, and had much the longer reach, and he had the best of the round. Meacock was not up to his usual form.

Featherweight—

C. S. Gross (Guy's) beat M. L. Malley (Bart.'s).

Gross, after having all the best of the second round, knocked his man out in the third.

C. S. Gross (Guy's) beat N. L. Koonenburg (Middlesex). Koonenburg made a series of blind rushes, and Gross, boxing very coolly, won fairly easily.

G. K. Thornton (St. George's) beat M. Sperber (London).

Final.—Gross won the first round, but appeared to get tired, and Thornton eventually won on points.

Lightweight—

I.—J. G. S. Thomas (Guy's) beat A. C. King (London).

Thomas, making good use of the straight left, had all the best of the fighting and knocked his man out in the second round.

II.—H. J. C. Ball (Bart.'s) beat S. W. Arundell (Middlesex).

Final.—Thomas boxed very well and although he went down in the third round after an unlucky right swing to the jaw, he appeared to be unaffected, and won very easily on points.

Welterweight—

R. G. Vaughan-Jones (London) beat Lister (Bart.'s).

J. W. Watts (Middlesex) beat R. V. Bowles (U.C.H.).

G. V. Lloyd-Williams (Guy's) beat R. A. Vaughan-Jones (London) on points.

Williams was winning all the time.

Final.—This was the most exciting fight of the evening. L. Williams had all the best of the exchanges till the end of the second round, when he stopped a hard right swing with his jaw, and was only saved from being knocked out by the gong. He was still very groggy at the beginning of the third round, but towards the end of the round he recovered and just got the verdict.

Middleweight—

A. J. Smyth k.o. J. B. G. Muir in the first round.

H. Trafford (Guy's) beat T. M. Marcase (Bart.'s). Trafford showed superior stamina, and won on points.

Final.—Smyth was too strong for Trafford, who boxed very pluckily, but never looked like winning.

Light Heavyweight—

N. M. Holloway (Guy's) beat Guilfoyle (Bart.'s). The fight was stopped in Holloway's favour in the third round.

Final.—N. M. Holloway (Guy's) beat McLeod (Middlesex).

Holloway showed splendid form and knocked his man out at the end of the first round. McLeod took a tremendous lot of punishment and it was only through sheer pluck that he stuck it as long as he did.

Heavyweight—

R. F. H. Duncan (Guy's) beat E. S. Vergette (Bart.'s).

Duncan was giving at least a couple of stone away, and in the first round was hard put to it to keep his end up. In the second round Duncan's superior fitness and his knowledge of boxing began to tell, and at the end of the third round he was hitting his man with both hands where and when he liked. A very good performance.

Inter-Hospital Cross Country Race.

The Annual Cross-Country Race for the "Kent-Hughes" Cup was held at Blackheath on March 8th. Only four hospitals competed, Guy's providing twelve men of the field of thirty-one. The weather conditions were extremely unpleasant, a hundred and eight mile an hour gale being dead in the faces of the competitors for the last mile. At the start Jago and Lightwood soon drew away from the rest and with Faull, Thomas and Chambers running together a short distance behind, and Theis lying eighth, the return of the Cup to the "spit" was assured. Very little change in places took place during the race. Lightwood went ahead at six miles to beat Jago by a hundred yards, and Darley, of Bart.'s went up to split the Guy's team. Otherwise the positions gained in the first mile were maintained, the rear being brought up by Maister, who kept up a very steady six miles an hour over a trying course.

Of our scoring five all ran well to finish in the first seven. It was hardly to be expected that Jago would beat Lightwood, but he ran a good race and was well ahead of the rest of the field. J. G. S. Thomas ran a fine race, after his tiring previous evening at the Inter-Hospital Boxing Tournament. If he had been able to train for running, he would certainly have given the leaders a lot of trouble. Faull and Theis both ran with great determination as did Chambers, so long as he took Thomas for one of the opposition. Once, however, he discovered his mistake he decided that there was no need to hurry and finished full of running. It is nice to know that Housden, who was prevented from running by doctor's orders, is no longer necessary to insure an overwhelming victory for Guy's.

After tea Jago, on behalf of the team, received the Cup from Dr. H. A. Munro, with characteristic ease and grace.

1. R. C. Lightwood (K.C.H.), 46 min. 16 sec.
2. M. E. M. Jago (Guy's), 46 min. 43 sec.
3. J. G. S. Thomas (Guy's), 48 min. 28s ec.
4. W. W. Darley (Bart.'s), 49 min. 11 sec.
5. J. L. Faull (Guy's), 49 min. 19 sec.
6. R. S. Chambers (Guy's), 49 min. 31 sec.
7. S. E. Theis (Guy's), 49 min. 44 sec.
8. R. M. Bates (London), 49 min. 49 sec.
9. A. Simpson (K.C.H.), 49 min. 56 sec.
10. L. I. Hyder (K.C.H.), 50 min. 49 sec.
11. W. T. R. Chapman (K.C.H.), 50 min. 53 sec.
12. R. H. Yelf (K.C.H.), 51 min. 6 sec.
—. H. L. Rees (K.C.H.), 52 min. 18 sec.
13. G. N. Golden (London), 53 min. 1 sec.
—. P. B. Atkinson (K.C.H.), 53 min. 27 sec.
14. L. O. Lindsay (London), 53 min. 42 sec.
—. J. D. S. Thomas (Guy's), 54 min. 2 sec.
—. H. A. Astley-Cooper (K.C.H.), 54 min. 4 sec.
—. R. M. Hastings (Guy's), 54 min. 29 sec.
—. T. M. Robb (Guy's), 54 min. 46 sec.
—. W. H. Dowell (Guy's), 55 min. 15 sec.
15. J. D. Allen (Bart.'s), 58 min. 15 sec.
—. G. C. Hughes (Guy's), 59 min. 52 sec.
—. J. Way (Guy's), 60 min. 39 sec.
16. J. A. Hickenbothum (Bart.'s), 61 min. 9 sec.
17. J. H. Willis (London), 63 min. 28 sec.
18. W. P. Greenwood (Bart.'s), 64 min. 15 sec.
19. E. S. Evans (Bart.'s), 65 min. 29 sec.
—. H. E. McLaughlan (Bart.'s), 66 min. 5 sec.
20. S. M. Power (London), 71 min. 20 sec.
—. H. A. Maister (Guy's), 72 min. 30 sec.

Result—

1. Guy's.—2, 3, 5, 6, 7=23 points.
2. K.C.H.—1, 9, 10, 11, 12=43 points.
3. Bart.'s.—4, 15, 16, 18, 19=72 points.
3. London.—8, 13, 14, 17, 20=72 points.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE date at the head of this page should surely be an excuse for the wildest outbursts of farcical extravagance. We are deplorably conscious, in fact, of our shortcomings. All Fools' Day, of all days, should be the day on which to out-scope the "Guyoscope," and yet we are here once more, as staid as ever. We were unable even to introduce an excellent little poem (dealing with examinations on April the First) which will appear later in the charming series of articles entitled "When the GAZETTE was Young," owing to the fact that alteration of the order of the articles would have involved too great a disarrangement of the series. A desperate attempt at humour from the Editorial chair was abandoned because, on re-perusal, it did not bring a smile even to the lips of its parent. As a final forlorn hope we toyed awhile with the idea of presenting our readers with three nearly blank pages of "Passim" inscribed only with the rubric "April Fool," but mature consideration convinced us of the unwisdom of such a procedure.

There is, however, some justification for the claim that this issue, though sober, in not lacking in scientific interest. The notes on Polycythæmic Repletion, to be found elsewhere in our pages, are especially worthy of the epidemiologist's attention.

IT is not our custom to embark upon the stormy sea of literary polemics. Such a policy is of doubtful value, and is, moreover, apt to become unpleasantly fatiguing. But we cannot ignore the remarks which a gentleman, writing over the pseudonym "Mr. London," contributed to the *Daily Graphic* of Thursday, March 16th, after the Rugby Final. The passages to which we refer were brought to our notice after our last issue had gone to press, so that we were unable to comment upon them at an earlier date. No other consideration could impel us, having once read the article, to forego the satisfaction of refuting the statements made so ill-advisedly by that industrious scribe "Mr. London."

The first of Mr. London's points we will quote in full. "They called it a football match, when Guy's and London met in the Final of the Hospital Cup yesterday. Certainly, the two fifteens played Rugby on the field; but really it was a 'rag.'"

Continuing his discourse after an interlude devoted to an accident to Lord Knutsford's hat, our friend went on to say, "What the King

thinks of medical students I do not know. He has knighted lots of them when, in after years they have won fame and fortune as great surgeons and great physicians; but yesterday he saw them in their native war-paint; and nearly all his attention was directed at the ragging, since it went on all through the game."

To imply that the recent Final Cup-tie was not really a Rugby match, but a rag, is manifestly absurd. Guy's gave of their brilliant best, and London, though out-classed, gave a magnificent exhibition of fine tackling and stubborn defence. As regards the spectators, we are convinced that no football teams ever had a more appreciative following.

The statement that the ragging went on all through the game needs no refutation. Anyone who watched the match must have been struck by the instant cessation of ragging at the commencement of each half of the game, and by the concentration of the supporters of both teams upon the play. We suspect that Mr. London did not watch the game himself.

We will not enter into a discussion as to the King's feelings towards medical students, beyond drawing attention to the fact that he has been to Inter-hospital Cup-ties before, and has apparently not been deterred by any ragging from coming again. We ourselves feel that His Majesty enjoyed his afternoon at Richmond, an opinion which we think is justified by the photographic evidence published in this issue. It is certain that he received a sincere and spontaneous welcome from all the students present.

Mr. London concludes his effort with a few quite unnecessary remarks about the performance of "The Co-Optimists" at the Palace Theatre, and the part played by the students who were there—remarks which only strengthen our conviction that his is a singularly jaundiced and myopic point of view.

We hear that the money collected on the occasion of the Inter-hospital Rugby Final page 132, it is evident that an even greater know that the efforts of the devoted band of collectors were productive of such good results, although, judging from the announcement on page , it is evident that an even greater response was anticipated.

In connection with this announcement, men at the Hospital will, we think, endorse our commendation of the action of the Students' Committee in returning to the London Hospital the barrel captured on March 15th. Intended as a tribute to the sportsmanlike behaviour of the London crowd, this action will, we feel sure, be appreciated by our erstwhile opponents.

Condolences are apt to be irritating, but we cannot refrain from expressing our sympathy with the Soccer XI. which lost the Inter-hospital Cup after coming so near to victory. To make matters worse, so many players were injured in the re-played Cup-ties that we were obliged to retire from the Private Clubs' Trophy Competition, the second team being engaged in another match. This is particularly galling in view of the fact that our Association XI. have had, until now, an unusually successful season. We hope that next year they will be able to look back upon a season concluded as triumphantly as this one was begun.

We hear with deep regret of the death of two of the older generation of Guy's men.

Dr. Sydney Poole Lowdell, who was 91 years of age, resided for the last 40 years at "Baldwin's," East Grinstead. After qualifying, he held the posts of Assistant Surgeon to Portland Prison, and Surgeon to the Royal Mail

Service. He was also Honorary Colonel of the Sark Militia.

It is our sad task to record also the death of Dr. George Thomas Willan, who retired some years ago, and who died at Melton Mowbray on March 23rd, at the age of 80.

We publish, on page 124, a letter which is being sent to all Guy's men who are Fellows, dealing with the election of representatives on the Council of the Royal College of Surgeons.

Mr. R. P. Rowlands is a candidate for one of the vacancies, and we desire particularly to draw the attention of Fellows to this letter, which expresses in cogent terms the reasons for supporting Mr. Rowlands' candidature.

It is unnecessary for us to enlarge upon Mr. Rowlands' qualifications, and we will content ourselves with emphasising the point, raised in the letter, that Guy's, the largest Medical School in London, is still represented on the Council by only two members of the Active Staff of the Hospital.

All Fellows are, therefore, asked to support their School by voting for Mr. Rowlands.

The Secretary of the Athletic Club asks us to draw attention to the date of the Hospital Sports, which is Wednesday, May 24th, and not May 31st, as announced in the last issue of the Gazette. It is hoped that every man will keep this date free and will compete in the various events if possible, or, failing this, will turn up at Honor Oak Park with his friends to watch the fun.

The team representing the Hospital in the Inter-Hospital Sports is chosen on the form shown in the Hospital Sports. Therefore, all are urged to train and show their best form in the Hospital Sports in order that those responsible for the selection of the Inter-Hospital team may be able to choose the best that the Hospital can produce. We must get that Shield back.

We feel sure that our readers will join us in congratulating Dr. C. H. Brooking, who was at the Hospital about 1840, on the occasion of his hundredth birthday, which occurs on April 3rd. Dr. Brooking is, we believe, the oldest doctor in England, and he is certainly the oldest Guy's man now living. He qualified in 1843. It must be satisfying to reflect, in one's old age, upon long years spent in the service of one's fellow-men. Not many of us have the fortune to score 100 not out.

We are glad to hear that a Guy's man has been appointed Professor of Surgery of the University of Wales. We congratulate Mr. A. W. Sheen (who is the first man to hold this position) upon his appointment, and wish him the best of luck in his new task.

A Correspondent has sent us a cutting, from a daily paper, dealing with the many old-fashioned "remedies" still, apparently, in vogue in some rural districts in England. Among those mentioned are the use of a garden snail for a bad cough, and that of a roast mouse as a cure for whooping-cough. Old wives' prescriptions contain at times an element of sound sense, but these two surely surpass any others in unsuitability and distastefulness.

Readers of Starling's "Physiology" perhaps remember a passage in the chapter on "Functions of the Cerebral Hemispheres," which runs —"As Bolton points out, 'A word, such as "mouse," at once sets in effect processes of association which pass to every projection sphere with the solitary exception of the gustatory, and even this may be aroused in a person who

has eaten a fried mouse in the hope of thereby recovering from an attack of whooping-cough.'"

This passage may have given rise to the wildest conjectures on the part of the diligent student unacquainted with traditional lore, and we have pleasure in elucidating the mystery it presents, for his benefit. Perhaps we have saved some unfortunate patient from a nauseating prescription!

WE must remind our correspondent, "Aponeurosis," that Guy's students are too fully occupied with their duties to find time for the suspension of even Communists from lamp-posts in Covent Garden.

Events of Interest for Fortnight ending April 15

April 3.—Clinical Lecture by Mr. Thompson on "Hæmaturia."

April 4.—5 p.m., Meeting of Dental Society in College Smoking Room.

April 5.—2 p.m., Clinical Lecture by Dr. Fawcett on "Clinical Symptoms and Signs of Local and General Arterio-Sclerosis, and of High Blood Pressure."

April 6.—7.45 p.m., Beggars Dance at Knightsbridge Hotel.

April 7.—Fevers Course at Plaistow Hospital commences.

April 10.—Clinical Lecture by Mr. Eason.

April 15.—Rugby: Guy's v. Neath (away).

Notice.

The following circular letter is to be sent to all Guy's men who are Fellows of the Royal College of Surgeons:—

Guy's Hospital,
London Bridge, S.E.1.
March, 1922.

Election to the Council of the Royal College of Surgeons.

Dear Sir,

We beg to inform you that Mr. R. P. Rowlands is a candidate for one of the vacancies on the Council of the Royal College of Surgeons.

Voting Papers will be sent out by the College on April 4th, and the Election will take place on July 7th.

Mr. Rowlands' name is well-known to all the Surgical world and needs no introduction by us, but quite apart from the claim that might be put forward on the grounds of his reputation, we feel that Guy's, the largest Medical School in London, is still inadequately represented on the Council by only two members of the Active Staff of the Hospital.

We therefore, as representatives of his colleagues, ask you to help your School by voting, and inducing others to vote, for Mr. Rowlands.

We remain, Sir,
Yours very truly,
J. FAWCETT.
ALFRED D. FRIPP.
G. BELLINGHAM SMITH.
A. W. ORMOND.

Guy's Employees' Association.

The Guy's Employees' Association held its last event of the Winter Session on Tuesday, March 21st, when Mr. W. H. Steavenson, F.R.A.S., gave a very interesting lecture to the members, entitled, "Our Neighbours in Space." The chair was taken by Dr. A. H. Fison.

Mr. Steavenson gave the members a brief review of the vast fields of that great science, astronomy, and with the aid of some excellent lantern slides, presented facts, mostly unknown to the audience, in a most attractive form.

Mr. Steavenson explained, with illustrations, the working of gigantic telescopes by means of which the sun, moon and stars are observed. He told us that the sun, which is several times larger than the earth, is a globe surrounded by an envelope of gaseous vapour, forming flames which supply heat and light to the earth. He took us to our neighbour the moon, and to the planets Mars, Jupiter and Saturn, and told us about several other heavenly bodies which we so often see, but know so little about.

Mr. Williamson, in proposing a vote of thanks to Mr. Steavenson, spoke of the interest which the present Staff and old Guy's students are taking in the Association, and thanked Mr. Steavenson on behalf of the members who were present, for his great kindness in giving the lecture. This was seconded by Mr. Homfray.

Dr. Fison, himself an Astronomer of note, spoke in his usual cheery manner and concluded with an amusing anecdote of one of his experiences as a lecturer on astronomy.

Publications Received.

The Isis, King's College Review, The Sphinx (Liverpool), British Medical Journal, Nursing Times, Architectural Association Journal, University College Magazine, The Hospital Gazette, Charing Cross Hospital Gazette, Middlesex Hospital Journal, Medical Journal of South Africa, Hospital and Health Review, Burma Medical Times, The Broadway, The Goldsmithian, Bedford College Union Magazine.

Some Points on Re-education of Muscles.

By CARL WESTMAN, M.R.C.S., L.R.C.P.

This important subject received a well needed stimulus during the war. Wherever the organic lesions proved favourable to recovery sound methods in the Physio-therapeutic Departments gave good results. The old-fashioned passive method of treating injuries to limbs—however important a part massage proper plays—was to a much greater extent, than had formerly been the case, supplemented by and in suitable cases entirely superseded by active co-operation of the patient himself. It is now generally recognised that paretic muscles rarely cure themselves and that prolonged inactivity is hindering to their ultimate recovery. The different curative measures that come under the heading of Physio-therapy all have their justification, but they must be looked upon only as a means to an end, preparing the way, as early as circumstances permit, for the all-important re-educative movements.

As in every other treatment, so in Physio-therapy, rational and methodical principles must be the guiding rule if any successful results are to be expected. For example, it is not sufficient to tell a patient with a paretic Deltoid to practice raising his arm from the side, because the muscle will be too weak to do that, a severe exercise, in the correct way. In trying to do so he will substitute for the Deltoid action elevation and an exaggerated rotation of the Scapula and possibly wriggle up the arm in some way or another. Another example of the patient being put to a disadvantage is the case of paresis of the Dorsi-flexors of the foot. If not shown the best way of giving practice to these he will probably lie on his bed with his foot in a more or less dropped position, struggling hard to bring it up, not realising that in this position some of the antagonistic calf muscles make up far too heavy a load to be overcome, particularly if they have undergone shortening.

A detailed description of the re-educative treatment in any stage of paralysed muscle does not come within the scope of this article. Such treatment can only successfully be carried out where access can be had to the various measures employed under the heading of Physio-therapy, viz., the different kinds of massage and electricity, whirlpool baths and exercises of various forms. Let it be noted here, *en passant*, that there are few cases where a combination of two or more of these measures does not prove to give the speediest results. The re-educative element of the treatment should, however, always be foremost in the operator's mind; his or her resourcefulness and encouragement will materially assist towards recovery.

The importance of re-educative movements cannot be sufficiently emphasized. Already before any visible contraction is present the patient's own mental efforts to such contraction should be encouraged at frequent intervals. The first visible sign of voluntary contraction should be hailed with joy, the patient himself be made to see it and by intensive practice—with frequent intervals for relaxation—endeavour to enlarge its amplitude.

When a patient, attending daily at the special department for treatment, has made sufficient progress to be allowed to do some additional practice on his own, it is of the greatest importance to show him exactly what to do. Such home practice is highly advisable, as it does not seem sufficient for a patient to have his limb attended to for 15 to 30 minutes a day and then left to look after itself for the remaining 23½ hours.

Re-educative exercises should be easy of execution and as "functionally true" as possible. By this it should be understood that the movement permits only of contraction of the particular muscle or group of muscles we wish to exercise, with the exclusion, as far as possible, of all irrelevant muscular work. In a special department this should be fairly easy by taking due regard to position of limb, suitable support and by giving right directions. Left to himself, however, the patient must be carefully instructed lest he, by faulty position of limb, etc., should give all the work to already healthy muscles. Further, as the exercises in this case must necessarily be free, the patient does them himself without anybody's help and without any artificial resistance being applied—it must be so arranged that they are *easy to do*. Thus ordinary free exercises, such as raising the arm sideways, or extension of the knee in the sitting position, are unsuitable in early re-education because gravity makes them too severe.

To obviate this difficulty the "pendulum" method will be found most helpful. A moderate weight, suspended by a string in the line of gravity, requires only a small force to be set in a to-and-fro motion. The greater the swing required the greater the force that must be applied.

This well known physical phenomenon can be applied with great advantage in several instances of muscular re-education, as two examples, to be described below, will suffice to demonstrate.

1. *Paresis of Anterior Tibial Group of Muscles.*—Patient is adopting a position like that shown in Fig. 1, standing on the good foot and resting with the other knee on a chair with the foot hanging free beyond the seat. Supporting himself against the back of the chair he should then make strong

and repeated efforts to dorsiflex his foot, being directed to bring his toes as near the chair as possible. If he is able to do a definite movement towards the chair, he should gradually let the foot return to its original position. Assuming a free anklejoint, the foot will here make up a pendulum of no big weight and only a small force—contraction of the Dorsiflexors—will be required to shift it away from the line of gravity. A second factor, facilitating the movement in this position, as compared with that with the knee extended, is the diminished resistance offered by the antagonistic Gastrocnemius, on account of its femoral attachments being approached to its insertion. Wherever muscles, antagonistic to others, which are paretic, pass over more than one joint, their hindering influence over the others' activity must be, for the time being,

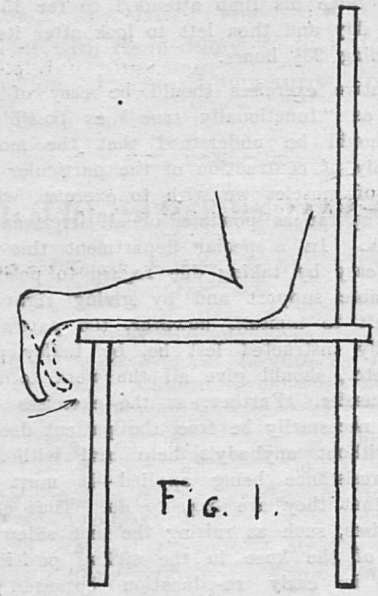

FIG. 1.

controlled by such position of limb as to ensure their *passive shortening*. In this relation it is of interest to note that this procedure in the early re-education of paretic muscles is exactly the contrary to that of the Orthopædic surgeon who applies splints for the purpose of *elongating* the antagonists. After a little consideration, however, it would be clear to anyone that the two methods—although they may seem at first to work apart—supplement each other admirably not least from the fact that, whereas the splints *keep* the paretic muscles in a state of passive shortening, the early re-educative movements should aim at changing this state of passivity into one of *activity*. The ideal procedure in practice would, of course, be to remove the splints several times a day for re-educative treatment.

The improvement of any muscle should be followed up by giving it harder work to do. In the exercise described above this can easily be done by building up the seat of the chair by cushions, etc., so as to make it into a sloping plane (Fig. 2). In this altered position more strength will be claimed from the Dorsiflexors, firstly, on account of the longer distance from the line of gravity, through the anklejoint to the imaginary line marking the physiological limit of the Dorsiflexion, secondly, by the greater resistance offered by the Gastrocnemius due to less flexion of the knee (see below).

Later, more severe practice for the Dorsiflexors may be done in the sitting position, when the patient with foot resting on the floor, is trying to lift the sole up. When the same movement can be done in the standing position, the antagonists

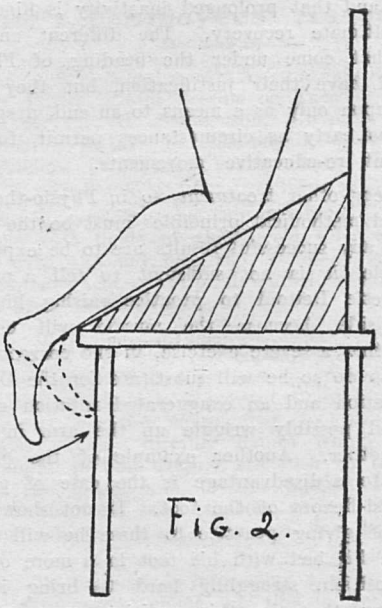

FIG. 2.

here putting up a considerable resistance, recovery may be considered complete.

2. *Paresis of Deltoid Muscle.*—The Pendulum method can be utilised with still greater advantage in the re-education of this muscle. Let us first remind ourselves of the normal action of Deltoid.

In raising the arm in the frontal plane from the side to the vertical position the Deltoid undergoes active shortening for about 65 degrees of the movement, which during that part is entirely confined to the humero-scapular articulation. After that Humerus and Scapula move together as one piece, the relation between them being maintained by static contraction of the Deltoid, and the Scapula being rotated outwards by the Trapezius and Serratus Magnus. This is continued until the arm has reached

a position of about 25 degrees from the vertical; then Scapula remains stationary and Humerus again moves on it by virtue of still further contraction of Deltoid, but probably materially assisted by Supraspinatus. In spite of its extremely short forcelever this muscle is here able to assert itself because of the greatest part of the weight of the arm being transmitted through its long axis.

Bearing in mind that even under normal circumstances Deltoid is working at a mechanical disadvantage on account of the weightlever being so much longer than the forcelever it is easy to see that no very marked paresis is needed to cause inability to abduct the arm. If in such a condition an exercise, such as described above, is attempted, the weight of the arm will prove too great for the Deltoid to overcome. By its limited contraction only a few degrees of pure abduction will result, the rest of the movement—as far as mechanical circumstances permit—being done by elevation and over-rotation of the Scapula. Clearly such a move-

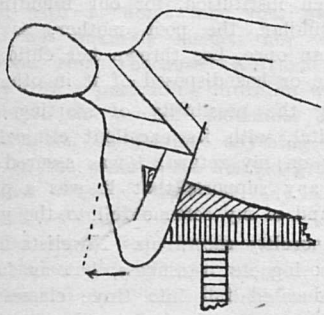

Fig 3.

ment will be unsuitable for a patient to attempt at an early stage of re-education. The "pendulum" method will be found more useful and to lead more speedily to recovery.

Let the patient recline on his side on a couch in somewhat less than horizontal position with the affected arm hanging free outside the end of it. By a broad loop of bandage sling the wrist to the neck so as to keep the elbow flexed to slightly less than a right angle. From the illustration (Fig. 3) it will be clearly understood that the upper arm here represents the pendulum suspended in the line of gravity. The patient should be directed to let his arm hang perfectly free without strain and repeatedly practice to move his *elbow* away from the couch. In so doing an almost isolated action of Deltoid is elicited probably with the assistance of Supraspinatus. The movement is easy of execution and the abducted position of the arm—or very nearly so—harmonizes well with the principle, universally adopted as correct, that passive elongation of paretic muscles is injurious and retards recovery. It is of some importance to direct the patient to move his *elbow* away from the couch. His mind is thereby led away from his shoulder and he is more liable to do abduction proper whereas, if not so told, he will invariably elevate the shoulder itself. The exercise can be made gradually stronger by making the patient's position less and less horizontal; bigger range of contraction will thereby be claimed to complete abduction, and gravity will more and more assert itself until sitting or standing position is reached. When gravity can be overcome in these positions, enabling a complete elevation of the arm to the vertical position, recovery of Deltoid has taken place.

Free and easy exercises as an additional feature of muscular re-education should be encouraged as early as circumstances permit. Besides being of direct strengthening benefit to the muscle itself their great importance lies in the fact that they encourage the patient's mind, suggesting less degree of helplessness by enabling the patient to see his limb move as a result of his own efforts.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Senior Dressers.

DEAR SIR,—The letter which you published on March 18th from Mr. J. M. Hurwitz, with reference to Senior Dressers, calls for a reply.

In deciding to restrict the number of Senior Dressers to six on each Firm, the School is not issuing a new regulation, but is only reverting to the pre-war custom. The appointment of Senior Dresser, it must be remembered, is to be regarded rather as an honour than as a routine Students' appointment, and, if more than six men were to be appointed to any one Firm, the reduction in "taking in" experience would greatly detract from the value of the appointment. During the war period and the first two post-war years, the number of available Students was so small that applicants for Senior Dresserships were invariably successful, and the impression arose that all men, irrespective of their previous records, were entitled to hold the appointment. Recently, signs have not been lacking that routine Hospital duties which demand sacrifices from Students are not always being carried out with that keenness which is traditional. It is, of course, not given to all men to be equally efficient, but the Medical Council, in future, will find it their duty to refuse, or defer, the appointment of Senior Dressership in the case of those Students who have not shown a spirit of willing service as

Surgical Ward Clerks and Junior Dressers. As a matter of fact, the restriction in numbers means that not more than 24 Senior Dressers will be appointed for any given period of three months, *i.e.*, even in the most crowded year, less than 20 per cent of the men will be unsuccessful in their first application. As men are permitted to apply more than once for the appointment in question, it will be seen that the chances of a really deserving Student failing to obtain it are extremely small.

The Students' curriculum in the Clinical period is arranged according to a definite plan; time is allowed for attendance in all the separate Departments; and there is no necessity for a Student to absent himself from any of the duties of his current appointment for the purpose of attending classes, or demonstrations, etc., which are arranged for a different stage of the curriculum. Such irregularities can only lead to chaos and should, obviously, not be encouraged.—I am, Yours faithfully,

T. B. JOHNSTON.
Dean.

Medical School,
Guy's Hospital,
March 29th, 1922.

Oxford Men in London.

DEAR SIR,—A letter appears in the present number of the GUY'S HOSPITAL GAZETTE, signed by D. R. Gawler and E. B. Strauss suggesting that an association should be started for Oxford Medical (Men) Students in London. I should like to remind the writers of the existence of the Oxford Graduates Medical Club which, I think, already meets the requirements of your correspondents. I would point out that under the new rules of the O.G.M.C. any Oxford Medical Graduate who has joined a London Hospital is eligible for election to this Club before he has taken his qualifying medical examination.

Meetings of the Club had to be discontinued during the war, but they have now been resumed and are held twice annually. New members are wanted, and if any Oxford man wishes to join, and will kindly let me have his name, I will see that it is brought before the Committee.

There is an entrance fee to the Club of £1 1s. and no further subscription.

The Summer Dinner of the Club this year will be held at Oxford.—Yours, etc.,

REGINALD C. JEWESBURY,
Hon. Sec. Oxford Graduates' Medical Club.

5, Wimpole Street,
Cavendish Square, W.
15th March, 1922.

Sterility and the State.

SIR,—I was very much struck by one paragraph in Dr. Gibbon's excellent article in last week's *B.M.J.* on "Sterility with reference to the State." He shows clearly that the chief cause of the decline in the birthrate in Europe to-day is the "Gospel of comfort" and its far-reaching influence. Amongst other causes he classes the high mortality of illegitimate children, which is ten times that of legitimate children.

May I quote his next paragraph in full:—"In Russia, before the war, I was much struck by the very large foundling hospital in Moscow admitting yearly about 15,000 children. There any new-born illegitimate child is taken and admitted without any question being asked, except, has the child been baptised, and if so by what name? If the child does not possess a name, one is given, and although the mother may be nameless, and never known, she has the power of following up the child there by his registration number and claiming him at any time should she be in a position to do so. Thus the children are educated and cared for until the boys go into the army or navy, or various trades, and the girls are trained as nurses or midwives. Hence these lives are saved to the State, whereas in this country where we have no such institution, for our foundling hospital is not similar, the poor mother, as I have known more than once, has thrown her child on the dust-heap to die or has disposed of it in other ways.

On discussing the possibility of starting such a foundling hospital, with its excellent clinical work, in this country on my return, I was assured that I could not get any support, that it was a premium upon vice, etc., and so my scheme fell to the ground."

Thus is our morality shown up. Novelists have for years been exposing its rottenness, but as far as I can see, the educated fall into three classes:—

1. Those who say it is wicked to think about such subjects.

2. Those who read, but absolutely fail to get any meaning out of what they read.

3. The very small minority who are not afraid to think for themselves.

Because this subject is one of the unpleasant and therefore wicked things, I venture to suggest that it is part of the job of the Medical Profession in general and the Ministry of Health in particular to forcibly open the eyes of our blind compatriots. The whole trouble is, in my opinion, caused by the habit of looking upon the illegitimate child as the product of vice à la Hall Caine.

I wonder how many people realise that the only particular in which the legitimate child differs from the illegitimate, is that a ceremony has been performed in one case and not in the other, and it is for lack of this ceremony that certain children are stigmatised as bastards for life, whereas they are the physical and intellectual equals of the others, given similar upbringing.

In view of the vital importance of the birthrate, it is time that Hardy and Wells were read with more

intelligence, and to the *very brave* I would recommend David Graham Phillip's "Susan Lennox."—I am, Yours, etc., R. S. C.

When the "Gazette" was Young.

SIR,—In your paper of March 18th, 1922, my old friend W. H. Spurgin writes, "There are not many of us 'Old 'Uns' left" and as I am older than he I am tempted to endorse his statement and also the other sentiments in his letter, and to add a small expression of the pleasure I have derived from perusal of the little reminiscences in "When the GAZETTE was Young," in the same issue—and first I would complain that it is a pity to detract from the lustre of that brilliant diamond, John Hilton; rough though some of the facts may seem, he was never brutal or malicious even to point a lesson. The tale of the poultice, which your contributor alters to a stinking ulcer, I disbelieve entirely, while that of the exquisite who went round the wards with yellow kid gloves on, a fashion of the late sixties, and who was advised to examine a rectum with a "don't take your gloves off," was true and not unkindly meant; nor was his advice not to wear rings (because "a friend had once accidentally torn a protruding intestine with a jewelled ring," before the era of abdominal surgery) given to his dressers, on joining, anything but humanely meant. On the other hand his old great coat which I, his last dresser, tried to buy as a souvenir, filthy and stained with every kind of discharge and snuff, was responsible for many of the failures, undeserved by his splendid operative skill and anotomical knowledge, which somewhat soured his temper. His presence was jovial, his voice pleasant, his eloquence—see "Rest and Pain"—but like his great contemporary, Sir William Gull, he abhorred carelessness, and hence made enemies and got from them his character for roughness. Gull was able to retire from Guy's about 1866 and, although he occasionally visited and lectured, there must be very few who saw much of him. His lecture on Typhoid, I think, was his last appearance and although I saw plenty of him it was not as a student.

The Prince of Wales' recovery added the pinnacle to the fame he began to build in Guy's wards, while Hilton was dissecting and Towne modelling; giants they were in those days truly, working, succeeding, and still living examples to us.

Wilks, of course, we knew and loved, a martyr to migraine, when tea and guarana were the only imperfect remedies, yet always at work and always ready to help and always remembering and encouraging any old student with advice and comfort. He was the *medicus medicorum*, and always saw more doctors than patients, considering himself well paid by their thanks—if he thought about fees at all.

Rees I clerked for twice and saw a good deal of, indeed I got my first guinea for taking a wealthy child to him with choreic aphonia. His lectures were not always only witty. I well remember a hydrocephalic skeleton decorated with fool's cap, clay pipe, etc., etc., which Rees ignored until, leaning on his wand, the lecture half over, he sighed and said, "Ah! gentlemen, if you had known that poor fellow as I did, during life, you would not have treated his bones so thoughtlessly."

A little man, riding under ten stone and a bundle of nerves, with a love for his "hat" and a fear of "hospital pins," which we in our ignorance, fresh from dissecting, ridiculed; his anxiety for both did not appeal to youth. Jim Hainsby deserves more notice. He was by way of being a great man. His desire was that we should know and name any bit of muscle he showed us from anywhere, and that we should not recognise him if we met him outside the Hospital gates. His evening coat and hat entitled him to the rank of Dr. Hainsby, and were comparatively smart. His great pride was to accompany some member of the staff to a private house to adjust his invention "Hainsby's Harelip Truss" (v. "Bryant's Surgery"), for which he was able to charge a separate fee.

As prosector I was unable to shirk the anatomy lectures, and I do not think many did, although I often wonder now how Cooper Forster's special lectures, or Arthur Durham's racy aids to memory would be received by mixed classes? We prosectors had rather festive times. We taxed all visitors a shilling which "Jim" spent for us in hot spiced beer, of which we were glad, for prosector work was hard and the winters cold in those days; he did not drink with us, but he charged fourpence on each pot! There were many—and still we are alive!

OLD 'UN.

Change of Address.

A. W. Sheen, Colonel, A.M.S. (T.A.), C.B.E., T.D., M.S., F.R.C.S., King Edward VII. Hospital, Cardiff, and Llandough House, Llandough, near Cardiff. (On appointment as first Professor of Surgery, University of Wales.)

Change of Telephone Number.

Geoffrey Marshall, M.D., M.R.C.P., 31, Wimpole Street, W.1., Telephone No. changed to Paddington 6923.

Football.

RUGBY.

GUY'S v. LONDON.

Final Tie, Inter-Hospital Cup Competition.

Though the day was dull at Richmond on March 15th for this Hospital Derby, nothing else was. His Majesty the King arrived five minutes before the time, and immediately walked on to the ground into the midst of the most hilarious rag one can remember. Immediately the revellers surrounded His Majesty, hats and caps were doffed, cheers and shouts of welcome rent the air, till suddenly someone started the National Anthem. Taken up by all, never did the grand old tune sound better than when thousands of strong-lunged Britons put into the swelling music all they knew. The scene and sound filled one with pride and bewilderment: pride in his obvious keenness on Hospital Rugger; bewilderment at the strange setting—His Majesty of England in the centre of all these gaily dressed students of Guy's and London. The teams were introduced to the King by the respective captains; the ball was placed and T. H. Vile, the referee, set the game going.

It was good to see London, our old opponents, in the Final again. One's mind went back to their teams of former days, great indeed, and almost of international strength. We do not forget H. C. Monteith of Scotland, Scott, that great English forward, nor the halves, Heale and Lindsay, T. P. Lloyd, the Welsh International, Alan Adams, of England and New Zealand. The team of this year is not so good, but its mettle is of the soundest. They were led by L. G. Brown. I needn't tell you of Brown; it is said that this was his last game, if so, he goes out of Rugger worthily fighting against frightful odds, with the greatest pluck, skill, and cheerfulness, and in the service of his Hospital.

We won by 6 goals 4 tries (42 points) to 1 penalty and 1 try (6 points). The scoring commenced five minutes from the start, Steyn going from midfield, cutting inside the London back and grounding by the post. Van Schalkwijk goaled. Five minutes later A. Daneel crossed wide on the left, E. E. Neser goaling with a splendid kick. Then came a try by E. H. Fouraker, after much good forward play. Handling accurately, the pack went downfield till Fouraker got over. Again one must commend Neser's play. In the tight Zondagh was heeling well. Biddle was helping much with his weight; he had come in for Duncan, who could not play owing to the proximity of the international on the 18th. K. L. Ward appeared to be London's scorer. There was some dash about the London try which savoured of much promise, but their efforts were spasmodic. In the tackling and saving they were good as a whole, but the loose work was no more concerted, than was the scrumming. R. D. Wheeler, C. Thomas, and others in the side, however, will see to it that London does not now look back, and from now on London will go forward to the proud position they once held in "Rugger." Albertijn cleverly scored a try from a pass from Sprong. Steyn got another, smartly following up a punt ahead, and Sprong also scored. Twice conversions were made. One kick by P. G. Harvey was a very fine goal.

Changing ends, L. G. Brown varied his position from forward to threequarter. But success still came our way. The ball was always out our side. Bekker was not much worried and Sprong was in good form. The threequarters had plenty of chances. Daneel got a couple of tries this second half; he has never run better. Albertijn helped him no end, and was, as always, in tip-top form. Van Schalkwijk was not so good; he dropped his passes and was oft times caught hesitating. Steyn got but one decent pass and that he scored from. He got another try this latter half, again from a forward kick. Steyn was in good form and with more chances he would have gained more tries. Bekker also got a try. London's only reply was a penalty kick, a good goal from long range. The total score is given above. Their remains nothing to do but congratulate W. D. Doherty on his unique record of leading a Guy's team to victory in this competition three years in succession. His forwards followed him to a man. His halves, on this day, had an easy journey. Van Niekerk had little indeed to do. The threequarters showed speed and cleverness. His Majesty presented the Cup to the Guy's Skipper. The milk can and its stalwart escort moved off. Everyone was pleased and the praise for our opponents was unstinted. Outplayed on the field, outnumbered in the rag, they proved themselves great sportsmen through it all.

Guy's Team.—A. K. Van Niekerk, A. Daneel, P. K. Albertijn, J. G. Van Schalkwijk, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, E. H. Fouraker, E. E. Neser, L. K. Watson, G. Zondagh, P. G. Harvey, F. J. Biddle.

GUY'S v. UNITED SERVICES.

To the great disappointment of the home supporters, the first match with the Services, which should have been played at Honor Oak Park in October, had to be scratched owing to the hardness of the ground. The Hospital were due at Portsmouth on Saturday, March 18th, but the international match with Scotland came on that day, hence Wednesday, March 22nd, was arranged for our visit to the South. A strong side represented the Hospital and it speaks well for the team that all turned out, even though the Cup is safely stored away in the College. The XV. are evidently bent on

THE KING TALKING TO DOHERTY.

(Sport and General Press Agency, Ltd.)

(Press Photographic Agency.)

A LINE-OUT.

(Press Photographic Agency.)

GETTING IT OVER.

(Press Photographic Agency.)

THE KING AMONG THE "RAGGERS."

(Press Photographic Agency.

THE MILK-CAN.

(Press Photographic Agency.)

THE ASSOCIATION XI.

(Sport and General Press Agency, Ltd.)

AN INCIDENT IN THE REPLAYED CUP-TIE.

finishing the season as strongly as possible. One is glad of this as thereby will the great reputation which this 1921—1922 XV. has built up, be maintained, if not enhanced.

H. Graham-Davies was out of town and in his place played G. Mostert. He did not score, but showed up in promising fashion and we shall doubtless keep him in view next season. There was a high wind on the Services' ground and we had it at our backs the first half. The Services had a good side out, but the threequarter line did not appear to very much advantage. Lieut. Stephenson was playing, but not Lieut. Bradley, the international. The centres were weak and through this fact the English halves, Davies and Kershaw, were rendered less dangerous than usual. The Guy's men marked these noted players, and with a weak line behind them, they were compelled to kick or combine between themselves. In the first half Steyn and Doherty got a try each.

In the second portion of the game Fouraker, who is developing into a regular try getter, gained a couple of tries, and Steyn also registered another. One try was awarded the Services through some good play in which Lieut. Agnew figured prominently. The whole of the six tries were unconverted. Davies had some long drops at goal this latter half, and he and Kershaw put in all they knew, but Guy's defence was quite sound and we were left rather easy winners by 5 tries (15 points) to 1 try (3 points), quite a good margin considering that against us were Commander Davies, Lieutenants Kershaw, Agnew, Stephenson and Williams-Powlett—all Internationals.

Guy's Team.—A. K. Van Niekerk, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, G. Mostert, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, W. H. Taylor, E. F. Fouraker, E. E. Neser, L. K. Watson, P. G. Harvey, G. Zondagh.

It was an interesting sight to watch the duel between Davies and Kershaw and the Guy's halves, Sprong and Bekker. The latter pair showed up very well. Kershaw can scarcely have found a bigger handful than Bekker this season.

ASSOCIATION.

FINAL INTER-HOSPITAL CUP.

GUY'S v. BART.'S.

This match was played at Hale End, on Thursday, March 9th.

Bart.'s started off with a rush and kept us penned in our half of the field for the first ten minutes, and a long dropping shot from Parrish from the left wing beat Hardy. Shortly afterwards Bart.'s had the misfortune to lose their right back, but the rest of the defence played up finely and we were not often dangerous. Before the interval Williams equalised.

After half-time the game was chiefly confined to mid-field play; Guy's were quite unable to break down the weakened Bart.'s defence—Oldershaw at right back and half doing fine spoiling work. Parrish again scored for Bart.'s with another dropping shot from the wing which scraped all along the cross-bar. Morgan equalised for Guy's seven minutes before time.

Guy's Team.—Hardy, Wakeford, Sennitt, Painter, O'Meara, Parry, Walters, Nicholls, Williams, Couch, Morgan.

FINAL INTER-HOSPITAL CUP—FIRST REPLAY.

This match was played at Champion Hill, on Tuesday, March 14th. Guy's won the toss and elected to play up-hill. From the start Guy's played the better football but their shooting was poor; Bart.'s, although playing downhill, were only occasionally dangerous. Nevertheless Bart.'s were the first to score, owing to miskicking by our backs, and Lloyd scored with a good shot. The score was unaltered at half-time.

On resuming Guy's were quickly on the offensive and scored twice in quick succession through Walters and Williams. Many more good chances were missed and about 10 minutes before the end another misunderstanding let Ross equalise for Bart.'s. Extra time was played, but there was no more score and even an extra ten minutes each way did not alter the score. We were unfortunate enough to lose Sennitt in this period.

The same team played for Guy's, except that Nicolai came in for Nicholls.

FINAL INTER-HOSPITAL CUP—SECOND REPLAY.

This match was played at Lloyd's Bank Ground. Bart.'s won the toss and played with a strong wind. Bart.'s were soon one goal up, Ross scoring from a good pass by Lloyd. Walters was showing up prominently for Guy's and he sent in two good shots which nearly scored; Williams and Nicholls also went very near. Painter was then crocked and soon afterwards Duncan, in clearing, kicked the ball hard on to Lloyd and it bounced into the net.

After half-time Guy's pressed continuously, but Couch also was crocked and both he and Painter were little more than passengers, and all Guy's could claim was one goal by Nicholls, leaving Bart.'s the winners by 2 goals to 1.

Duncan played in Sennitt's place and Nicholls returned to the team.

Throughout the three games fortune fluctuated from one side to the other; at Hale End Bart.'s were unfortunate not to win, their ten men proving more than equal to our eleven.

In the second match we deserved to win on the run of the play, but the finishing of the forwards was weak.

In the third match we were unfortunate in having Painter and Couch crocked.

Collections on the day of the Rugby Final.

The object of the little outing undertaken by the students on Cup Final day having been mainly to collect funds for the Hospital, it is perhaps not unsatisfactory to learn that the result was as follows:—

	£	s.	d.
Amount in Notes	9	10	0
,, Silver	259	10	9
,, Copper	88	5	0
,, Cheque	1	1	0
,, Sweep	2	16	3
Total	£361	3	0

Number of Boxes Issued 105. Average £3 8s. per box.

This sum was not as large as one would have liked—the object was to raise £1,000. But it was necessarily a "rush" collection and the fact that the amount was gathered in at the rate of over £320 an hour speaks well for the ardour and adroitness of the collectors, especially when it is realised that the majority of coin was small silver and copper. Apart from the generosity of the public, the arrangements were greatly facilitated by the courteous sympathy and valuable co-operation of Mr. Homfray and the Appeal Fund Committee.

Perhaps it would not be out of place to say that, as a tribute to plucky and jovial good sportsmanship against heavy odds, and the splendid spirit shown by the London Hospital throughout the day, the Students' Committee feel sure that they have the general assent of public opinion in deciding to return the mascot captured by such a predominance of numbers.

Appointments.

Arthur Bulleid, M.R.C.S., L.R.C.P., L.D.S., to be Visiting Dental Surgeon to the Royal Bethlem Hospital.

Out-Patients.

MONDAY—At 9 a.m. to 10 a.m.
Medical—Dr. Mutch.
Surgical—Mr. Hughes.
Children—Dr. Cameron.

At 11.30 a.m. to 12 noon.
Gynæcological—Mr. Chapple.
Ophthalmic—Mr. Ormond.
Throat and Ear—Mr. Layton.
Orthopædic—Mr. Trethowan.

At 5 p.m. to 6 p.m.
Male V.D.
Female V.D.

TUESDAY—At 9 a.m. to 10 a.m.
Medical—Dr. Hunt.
Surgical—Mr. Bromley.

At 11.30 a.m. to 12 noon.
Skins—Dr. Barber.
Ophthalmic—Mr. Eason.
Throat and Ear—Mr. Mollison.
Tuberculosis—Dr. Marshall.
Genito-Urinary—Mr. Thompson.

WEDNESDAY—At 9 a.m. to 10 a.m.
Medical—Dr. Marshall.
Surgical—Mr. Slesinger.
Children—Dr. Cameron.
Nervous—Dr. Symonds and Sir Maurice Craig.

At 11.30 a.m. to 12 noon.
Orthopædic—Mr. Trethowan.
V.D. Female—Miss Rawlins.

At 5 p.m. to 6 p.m
Female V.D.
Male V.D.
Tuberculosis—Dr. Marshall.

THURSDAY—At 9 a.m. to 10 a.m.
Medical—Dr. Ryle.
Surgical—Mr. Turner.
Skins—Dr. Barber.

At 11.30 a.m. to 12 noon.
Gynæcological—Mr. G. Bellingham Smith.
Ophthalmic—Mr. Ormond.
Throat and Ear—Mr. Layton.

FRIDAY—At 9 a.m. to 10 a.m.
Medical—Dr. Poulton.
Surgical—Mr. Davies-Colley.
Children—Dr. Cameron.

At 11.30 a.m. to 12 noon.
Ophthalmic—Mr. Eason.
Throat and Ear—Mr. Mollison.
Tuberculosis—Dr. Marshall.
Genito-Urinary—Mr. Thompson.

At 5 p.m. to 6 p.m.
Male V.D.
Female V.D.

SATURDAY—At 9 a.m. to 10 a.m.
Medical—Dr. Marshall.
Surgical—Mr. Slesinger.
Nervous—Dr. Symonds.

Some Notes on Polycythæmic Repletion Based on Four Cases from the V.D. Department, Guy's Hospital.

During the last few months four pronounced chronic cases of this distressing and almost universal complaint have come under observation, and in view of the fact that the usual course of the disease is intermittent, or at least remittent, it is thought that a few notes on this severe type might be of interest to research workers.

It will be as well to pass under review not only the special signs and symptoms shown by these cases, but also the more common ones associated with the disease in its incipient stage.

Ætiology.—The condition is of interest to epidemiologists as showing an incidence curve with a double rhythm. One rises with a slow even swell to reach its maximum in the months of March, July, September, and December, dropping with an almost vertical decline on Quarter days. The other curve, a short one, reaches its maximum early in the week, and drops on Saturdays.

Incidence.—This is almost universal, though the disease seems only to attain its full virulence in the Junior Staff holding part paid appointments.

Symptoms.—In addition to the common symptoms as headaches, lassitude, feeling of boredom after work, there is distortion of vision, easonophobia, introspection, and eyritis. Such patients walk with a dejected gait, and tend to agglutinate on the Colonnade steps. Alcohol has a marked chemiotactic action on such. On passing the War Memorial they may be observed to scan the names with an expression of but thinly-disguised envy. The persistent perusal of the last pages of the *B.M.J.* is a valuable and almost pathognomonic sign. Another not unusual feature, and one which is very well shown in the cases who form the text of these notes, is the liability of the patient to exacerbations of an intensity almost amounting to paranoia, which may follow unguarded remarks. In these cases the exciting cause, which has reduced the patients to a stage of gibbering, is the recent publication of an eyronical report.

Treatment.—Alleviation may almost invariably be obtained by judicious application of butter, or the exhibition of the heavier metals, except Mercury, in massive and increasing doses. A permanent cure requires either the total elevation of the patient, or his removal to more sympathetic and lucrative surroundings.

Some authors confuse the condition with cases of fulminating hæmorrhagic satisfaction.

In conclusion I must acknowledge the kind assistance I have not received from the Directors of the V.D. Department, or at any rate their kind abstention from interference.

THE WORM WITH THE SWAB.

When the "Gazette" was Young.

(Continued).

EXAMINATIONS AND EXAMINERS.

It is a debated point whether after all the system of examination in vogue then was not more a test of a man's memory than his general ability and intelligence. Some earnest, painstaking men of good tact, general ability and common sense, have wretched memories, when it comes to the test of the Primary Fellowship or London University Examinations. One such man I knew, who I am sure would have made a most successful and excellent family doctor. He worked hard and learnt, but could not remember. I remember he came to my room once a few days before the Primary Fellowship, I was working my very hardest, for the ploughing was most unmerciful at that time, chiefly due they said to a certain pair of examiners, one of whom was popularly said to "vex all very nervous pupils." He certainly was most irritating, and I met him often. But more of that anon. On that night when my friend came in for a little break in the night's reading, he said: "I have been reading up the fibula. I have read it in Gray and Holden, and Ward. I think Ward is the best of the three and he divides it into such and such borders, and such and such surfaces. I have drawn up a better plan, which I think makes it easier to learn." He then proceeded to elaborate his anatomical scheme, which I followed with some difficulty, as the fibula was one of the "tit-bits" I had

reserved to the last. In a few weeks, however, I thought I was *au fait* as regards the fibular anatomy and asked my friend to repeat his method of grouping the borders and surfaces, so that I might compare it with the classification I had adopted. Gone! Vanished! He hardly knew the right fibula from the left. So in all difficult details and classifications requiring accurate memory, he could not retain them. He was intelligent and of good literary knowledge, but cursed with a memory of no tenacity. He would have made an excellent doctor, but the examinations drove what little he knew entirely out of his head.

The knowledge of abstruse facts is quite necessary in its proper place, but what general practitioner is one whit the worse for not knowing the exact relations of the internal maxillary artery, the vidian nerve, or the attachments of the various component muscles of the spinal erectors? What surgeon in tying the femoral, or doing a "Symes," cares one atom whether "Sam" is pulling his "arm," or Timothy "vexing" him? Useful, may be, for "honour" and competitive examinations, but not for an ordinary "pass."

Edward Trimmer.

Whilst speaking of the College, there are one or two personal matters connected with the Staff and examinations which, I think, are worthy of being put on record. Edward Trimmer was secretary in those days, and in many respects he was a remarkable man. I will not dwell on these particulars, as they have already been put on record, but will content myself with confirming from my own experience the fact of his colossal memory. It was deservedly the first point noticed in the obituary notice in the *B.M.J.* Although he frequently wrote to me in the middle sixties, I never saw or conversed with, him except on paying my fees or other formal occasion, and these interviews, as all College men know, were limited to the fewest possible words and moments. In fact mine was one of the thousand strange faces which he but caught a transient glimpse of each year. With any other man it would have been thought a wonderful thing if the association between name and features had been mentally retained more than a few brief moments. Putting all occasions together I cannot have been in his presence five minutes all told. Yet years after I left Guy's and the College of Surgeons, I was at a large public function held in London crowded with men who had re-assembled from all parts of the world. I had just left a man on leave from India. We had shared the same rooms as students and had been very intimate. When I accosted him he had failed to recognise me; mark this. Only when I sang him a bar from one of his own past favourites did he recall my name and features. This happened in other instances. On leaving him, half way up the big stone stairs, on a landing stood Edward Trimmer. He stopped me and held out his hand and said, "How do you do, Mr. Blank?" "What! How can you remember my name," I said. "O, yes! I can remember you quite well," he replied solemnly. This is, in my opinion, the most wonderful instance of long duration of impression from the slightest contact with which I am acquainted.

Many of my friends have suggested that as I had held an appointment at the College which, for a time, necessitated my daily attendance at the College, it was not such a very great feat of memory as it seems.

It would have been a just comment had my duties brought me in contact with Trimmer. As a matter of fact, we never saw each other on these occasions.

College of Surgeons.

Another functionary at the College whose virtues, I believe, have not been recorded was "William." In his early manhood in those far-off days he was well known to all frequenters of the College. We always thought of him as a "porter," but he was a genial pleasant man. I passed five examinations of one sort and another, at the College, and in each one the results were communicated by a different method. At the final for the M.R.C.S. the way was peculiar. At the end of the *viva voce* we were all huddled into a small apartment, jocularly known as the "funking room." Here we waited in fear and trembling for what seemed an interminable period. At last "William" appeared with a paper in his hand, and, standing against the closed door, stood amid breathless silence to read out the names of those who had failed. The suspense was awful, and the serenity of his pleasant countenance seemed an outrage on the awfulness of the occasion.

He divided us into groups of four, and after each group those whose numbers had been called, walked out of the room. When the door was once more closed the next four were

dealt with. Another Guy's man, who has long since retired from the Staff, and myself were in the last four. My number was 123, the last but one, his was 121. We stood talking and thinking he never would get to our group, so leisurely did William get through his list. At last, however, our lot of four was all that was left unfinished. I recollect well the prolonged dramatic pause in which William held up the paper in front of him in silence, not a muscle of his face moving. Then most slowly and solemnly the number 122 fell from his lips. My friend breathed freely and smiled. He was safe. But again a pause, William still held up the paper. There were only two numbers left, and it was plain that one at least had to walk out, which was it? Then for one moment his eyes left the sheet and looking at me, I thought I saw in his expression, a diabolical and sinister enjoyment of our agony, he again shaped his lips, slowly pronouncing 124. I was safe, and naturally the tension was immediately relieved and the pain forgotten. But I think the natural dramatic talent of William passed unnoticed by the majority who only knew him as a College "porter."

When I was prosector at the College he was the man who attended us and saw to all the arrangements of the "parts" and to our various little wants. William was in no way obtrusive, but a most attentive and civil officer. He never forgot his place and station, and after a time we found it not only possible, but congenial, to take William into our counsel, as to any anatomical difficulty which occurred. I was at that time as well up in anatomy as at any period, or even better. My fellow prosectors were also men who knew their Gray and Ellis well. Nevertheless, not having any books with us, we were at times a bit hazy as to some little fact or other, but William was able always to put us right. So that at length it was to him we appealed instead of the "Demonstrator," who was not a *specially* good anatomist. In fact, we all agreed that William knew his anatomy better than any one of us. and, to his honour be it said, it never ruffled or altered his genial and deferential attentions.

A Dramatic Scene.

Returning to Guy's, one picture is permanently impressed on my memory of the ultra-comic style. Its occurrence and development was no sudden and tragical that all the men in the old Anatomical Theatre, and it was full, were held spell-bound. I never saw or heard anything so suggestive of comic opera or pantomine in my life, but whether my description will enable the reader to visualise it is another matter. There may be still a few remaining who saw it. If so, it is impossible for them to have forgotten.

It occurred during one of the lectures to 1st and 2nd year students; and here let me say that these lectures were a treat to listen to, the lecturer was a most able man and one much respected by all the better class of students. He was one who spared no pains to make his lectures as instructive and educational as possible, so as to fill in by demonstration and experiment what might be called the hiatuses of text books. Unfortunately his delivery was not of the best. He was not always sure of his h's, and we felt that his nervous, self-conscious manner was due to the fact that he was aware of the danger of getting too absorbed in his subject.

The theatre was always full, in fact I may say, crowded, and amongst the men there were naturally a few who might be called, well, say, the "sediment" who did not listen themselves and were constantly striving by their monkey-tricks to divert the attention of others from the lecture. Of these there was one, a big, bulky, clean shaven man, who always pretended to go to sleep during the lecture. Finding this was tolerated, he gradually added slight embellishments, such as an occasional snore. He and his colleagues were delighted to find that these antics increased the lecturer's nervousness, who occasionally glanced in his direction and blushed, but took no further steps. We all felt the position acutely, and heartily desired to see a prompt and decisive remedy applied. But the clown felt he was safe and quietly played up to his followers during each lecture. As far as the Directory can be trusted all the dramatis personæ have been long dead, for it is close on 60 years ago.

The climax arrived when the sleepy hero was roused from what was apparently sound sleep. "What do you want?" he said. He was shown the head of a pin which had been stuck through the centre of the crown of a black silk hat, and pressed down so that the pin head was buried in the nap. He was challenged to get the pin out by means of

seizing it with his huge prominent incisors. "I'll bet you can't do it?" "I'll bet I can," he said, and forthwith pressed his face and mouth close down on the nap, now turning to the left and now to the right: he did not desist until he had tried every position his face and teeth could assume. The sight of a man apparently worrying the top of a hat did not fail to draw the attention of all the theatre, even the lecturer looked now and then towards him, but made no remark. All efforts, at last, proving useless, the hat was put down, with the pin still in position. Simultaneously a loud peal made the theatre echo, all eyes being fixed on the hero of the hat. Seeing where all eyes were directod, the lecturer followed their gaze. His countenance became inflamed as he shouted: "Leave the—the theatre!" No notice was taken. Again, in stentorian tones, the command repeated "Leave the theatre, sir!" "What, ME, Sir?" was the innocent reply. Meanwhile the whole theatre full of students was convulsed with laughter. The uproar was great. It took the speaker's loudest tones to be heard above the din, as he kept repeating, "Leave the theatre, Sir."

The innocence on the hat performer's face was quite unmistakable; it was pathetically genuine. He could hardly believe his ears. What had he done? Why were all the men staring at him? Why was he, in anger, commanded to leave the theatre? He had tried to pull out the pin with his teeth, but even that was done quietly, and that was all over now. He had put the hat down. "Me, sir? What! me, sir?" he kept repeating in most injured tones. He could not understand the situation at all. At length by the advice of his friends he slowly left the theatre, amid screams and roars of laughter which it was impossible to control. The lecture was practically at an end. What happened subsequently I do not know, but I think that was an end of this foolish fellow's performances.

The fact was, that the owner of the hat previous to sticking the pin in the crown had liberally rubbed into the "nap" a quantity of powdered charcoal. In his efforts to extract the pin the performer had rubbed this well into all the prominent parts of his face. But as he could not see his own face, he was ignorant of the awful picture he presented. I never saw a more striking piece of comedy. It was so unexpected and dramatic; the acting perfect, the close juxtaposition of opposites, the forcible comparison of two adverse extremes, was so evident and intense that no one could resist its influence, or ever doubt again that in such relative positions lay the very soul of wit.

(To be continued).

Primary Cancer of the Skin.

On Thursday, the 16th March, Dr. Darier, the famous French dermatologist, the Prince of Dermatological Histology, as Sir James Galloway called him, read a most interesting paper on Cancer of the Skin before the Dermatological Section of the Royal Society of Medicine.

He said that three points were of primordial importance to the physician:

1. Its etiology.
2. Its malignancy.
3. Its power of resistance to actino-therapy.

He discussed the different methods of producing cancer and said that the most successful results had been obtained by the action of coal tar on white mice.

He raised the point of heredity and suggested that there was more than mere coincidence in the occurrence of cancer in several members or generations of the same family.

He then classified Cancer of the Skin into three groups which he called (a) Typical Cancer; (b) Atypical Cancer; (c) Metatypical Cancer of the Skin; the classification being entirely based on morbid histology. The "Typical Cancer" corresponds to what is usually termed in this country prickle-cell carcinoma. He calls it "Typical" because the cells are exact reproductions of the cells of the skin reacting in the same fashion, forming "cell nests," the centre of which closely resemble the keratinisation of the epidermis. The "Atypical" Cancer corresponds to what is usually termed "Rodent Ulcer." The cells are atypical. They never keratinise and do not form "cell nests." They never form secondary deposits. This form of cancer is baso-cellular. He laid stress on the fact that this type of cancer could be found elsewhere on the body besides the face. He showed several slides to illustrate his view that the origin may be from a hair follicle, from a sebaceous gland or from the basal cells.

Here he made out a very fascinating point: He suggested that we must revise our views of the cancer cell. For years, he said, we had been taught that the less differentiated the cancer cell was, the higher was its malignancy. And yet, he added, we have here exactly the opposite. While the baso-cellular carcinoma of the skin is composed of undifferentiated cells it is of a very low malig-

nancy, recurring locally, but never producing secondary deposits; the prickle-celled carcinoma which shows marked differentiation is of the highest malignancy, producing secondary deposits and resisting actino-therapy.

He then passed to a third type which is reality was the subject of his paper because it was something new. This he designated as "Metatypical" because in almost every respect it was a sort of transition between the last two. In this type one could find both basal cells and "cell-nests." This was, he felt convinced, a type that required considerable thought. It was no doubt this type that would be mistaken for a rodent ulcer and would sometimes in vain be treated by actino-therapy. This type sometimes produces secondary deposits and does not always do well with actino-therapy.

He concluded by saying that every growth should be sectioned as soon as ever it reaches the hands of the doctor, before any treatment is contemplated. It was only after a thorough histological examination of a cancer of the skin one could decide about the treatment. Whereas a prickle-celled carcinoma should always be treated surgically, a knife should never be used for a baso-cellular carcinoma which always responded to treatment by X-rays or radium. One had, however, to use one's judgment with regard to a metatypical carcinoma. If it involved some vital organ like the eye, then actino-therapy might be tried, otherwise surgery was the treatment.

Analysis of 141 Operations for Gall Stones.

By W. K. DAVENPORT, M.B., B.S. (Melb.),
House Surgeon, St. George's Hospital, S.W. 1.
Late Clinical Assistant, Guy's Hospital.

The records from which this analysis is made are taken from the reports of Guy's Hospital for the years 1914—19 inclusive. Only the reports of cases where gall-stones were actually removed at operation, have been used and those cases in which biliary calculi were found only at the post mortem examination, have been eliminated. The records of *all* the firms which were operating from 1914—19 have been examined, and during the six years (1914—19) 141 operations for the removal of gall-stones were performed with a total of 8 subsequent deaths.

Operation.	No. of Cases.	No. of Recoveries.	No. of Deaths.	Percentage of Mortality.
Cholecystostomy ...	85	79	6	7·1
Cholecystotomy ...	5	4	1	20·0
Choledochotomy ...	13	13	0	0
Cholecystectomy ...	47	47	0	0
Cholecystenterostomy ...	1	1	0	0
Cholecyst gastrostomy ...	1	0	1	100·0
Cholecyst duodenostomy	1	1	0	0

Appendicectomy was also performed in 13 of the above cases.

Cause of Death.—

In the 8 deaths following operation the following conditions were observed:—

Post operative collapse in 2 cases.
Post operative peritonitis in 1 case.
Fatal respiratory complications in 2 cases.
Carcinoma of biliary tract in 2 cases.
Post operative mania in 1 case.

Sex Incidence.—

Of the 141 cases, 108 were females and 33 males.
Percentage Rates 76·6: 23·4.

Age Incidence.—

Age.	Cases.	Percentage.
20—29	10	7·2
30—39	32	23·2
40—49	46	33·3
50—59	32	23·2
60—69	16	11·6
70—79	2	1·4

The youngest case was a girl, æt. 20.

The cases over 70 years were both females, one of 74 who recovered and was discharged as cured, the other of 71 who died shortly after operation.

Recurrence.—

No definite case of recurrence was found.

Conclusions.—

The results of the cholecystectomy cases with no deaths in 47 consecutive operations are very striking.

Though the total mortality is 5·7 per cent for the 6 years that for the 5 years subsequent to 1914 is only 2·7 per cent.

The ratio of females to males bears out very closely the statistics of the Mayo Clinic, where the ratio is given as 77 : 23.

Guy's Hospital.

Abstract of Summary of Anæsthetics and Operations for the year 1921.

The number of cases in which general anæsthetics were administered was 8,070, among which were 74 intratracheal insufflations of ether, and 30 intratracheal insufflations of ether plus a general anæsthetic. Spinal analgesia was also employed on 24 occasions, and on 41 occasions spinal analgesia followed by a general anæsthetic. On 3 occasions intrapharyngeal ether was employed, and on 18 occasions intrapharyngeal ether plus a general anæsthetic. The total number of operations was 7,736 in wards (Bright Ward excepted), special departments, out-patient departments, and surgeries. There were five deaths which were reported to the Coroner as possibly being due to the anæsthetic.

There have been 8,644 cases of general anæsthesia in the Dental Department; 7,425 under nitrous oxide gas, and 1,219 under ethyl chloride.

Operations done on the medical side are entered under the assistant surgeons corresponding to the physicians or assistant physicians in charge of the wards, the table below showing how many operations are actually performed in these wards:—

ANÆSTHETICS.

A.C.E.	1
C.E.	659
Chloroform	166
Ethanasal	13
Ether (including gas and ether)	136
Gas, and gas and oxygen	1,020
Intratracheal insufflation of ether	74
Intratracheal insufflation of ether + a general anæsthetic	30
Intrapharyngeal ether	3
Intrapharyngeal ether + a general anæsthetic	18
Spinal analgesia	24
Spinal analgesia followed by a general anæsthetic	41
Other anæsthetics and sequences	5,909
	8,094

ADMINISTRATION OF ANÆSTHETICS.

Staff Anæsthetists	1,958
Visiting Staff	364
House-Officers	4,647
Other Qualified Men	1,125
	8,094

OPERATIONS.

Tabulated According to Wards and Departments.

Astley Cooper	246
Cornelius	275
Lazarus	283
Job	363
Naaman	379
Luke	324
Patience and Samaritan	267
Evelyn	179
Charity	319
Dorcas	421
Lydia	370
Martha	292
Eye Wards	858
Addison	57
Mary	58
Stephen	55
Esther	54
Queen Victoria	479
Children's Ward	13
Isolation	9
Out-Patients	1,997
Front Surgery	377
Back Surgery	48
Nurses' Sick Room	13
	7,736

Turning to the General Wards it may be noted that the totals of operations are as follows:—

Surgeons	804
Assistant Surgeons	927
Specialists	139
House-Surgeons and Assistant House-Surgeons	685
Dressers	381
	2,936

The remaining 776 operations, bringing the total up to 3,712, were performed by other operators.

It should be remembered that no account is taken of operations done either under local anæsthetics or without anæsthetics at all.

Operations in the Obstetric Department (Queen Victoria and Patience Wards) number 476, of which 229 were performed by the obstetric surgeons, 68 by the obstetric assistant, 73 by the gynæcological assistant, 84 by the obstetric residents, 3 by dressers, while 19 operations were performed by other operators.

The operations upon ophthalmic cases in the wards, number 145, of which 87 were done by the ophthalmic surgeons, 26 by the ophthalmic assistants, 15 by the ophthalmic house-surgeon, 10 by ophthalmic dressers, and 7 by other operators.

There were 723 operations for throat and ear diseases in the wards, 295 by surgeons, 256 by clinical assistants, 110 by the house-surgeon, 57 by dressers, and 5 by other operators.

In the Orthopædic Department 139 operations were performed, 102 by the surgeon of the department, 22 by the Orthopædic Registrar, 14 by the clinical assistant, and one by another operator.

In the Genito-Urinary Department 99 ward operations were performed, 58 by the surgeon, 33 by the clinical assistant, 4 by the Genito-Urinary House-Surgeon, 2 by dressers, and 2 by other operators.

In the Venereal Department there were 10 ward operations performed.

19 operations were performed on patients in skin beds.

In the Front and Back Surgery 425 operations were performed, 226 by house-surgeons and out-patient officers, 179 by dressers, and 20 by other operators.

In the General Out-Patient Department 584 operations were performed, 528 by dressers, 37 by assistant house-surgeons, 2 by surgeons, and 17 by other operators.

In the Special Out-Patient Departments, there were 1,215 operations upon throat and ear cases, of which 84 were done by the surgeon, 110 by the clinical assistants, 189 by the ophthalmic house-surgeon, and 810 by dressers, while 22 were by other operators.

In the Orthopædic Department 189 operations were performed, 50 by the surgeon, 71 by the Orthopædic Registrar, 64 by the clinical assistant, and 4 by dressers.

Reviews.

Index of Treatment. Edited by Robert Hutchison, M.D., F.R.C.P., and James Sherren, C.B.E., F.R.C.S. Eighth Edition. (Messrs. John Wright and Sons, Ltd.,, Bristol.) Price 42s. net.

The practitioner or student who wishes to possess a guide to treatment, suitable for reference, could not do better than obtain a copy of this volume. The value of the work has been proved by the success of previous editions. Indeed a mere glance at the list of contributors will convince the reader that only the best of material is to be found within its pages.

The subjects are arranged alphabetically, and a convenient feature of the work is the printing of large type headings at the top of each page, so that it is a very simple matter to look up any desired subject.

In the new edition various sections have been rewritten, notably those on diabetes, electrotherapeutics, and mental diseases. Among new subjects not hitherto dealt with one may mention kala-azar, snake-bite, transfusion, encephalitis and the surgical treatment of constipation. It is interesting to note that Mr. Lockhart-Mummery in his article upon the last-named subject, advocates complete colectomy in some severe cases of atonic constipation, although he admits that the method is hardly justifiable unless employed to prevent a patient from becoming a hopeless invalid, when all milder methods have failed.

The book contains a profusion of prescriptions suggested by physicians with special experience in the treatment of the diseases under discussion. In addition to these a section is devoted to Prescribing, and a most useful account is given of the examples of incompatibility met with in prescribing the common drugs.

The publishers are to be congratulated upon the excellence of their production. The type is clear and easily legible, while the general arrangement of the work leaves little to be desired.

An Introduction to Dermatology. By Norman Walker, LL.D., M.D., F.R.C.P. Seventh Edition. (Messrs. W. Green and Son, Limited.) Price 21s.

In the Seventh Edition of this volume the author, while revising the work and bringing it up-to-date, has not attempted to enlarge its scope or to make it other than a students' manual, preferring to preserve the characteristics of the previous editions. It is for this reason that many newer methods of treatment have not been so fully discussed as they might have been in a book designed for the specialist; and some of the advances in dermatology which are still a matter of controversy are left to the expert, while the student is presented with an account of better established views and methods.

After an introductory chapter in which the structure and functions of the skin, and diagnosis and treatment are dealt with in general, the book proceeds to a systematic account of the diseases of the skin. The classification adopted is modelled on that of Unna, skin affections being divided into groups under the headings—anomalies of sensation, anomalies of secretion, inflammation, new growths, malformations, and anomalies of pigmentation. Excellent illustrations accompany the text.

The type is good, and the general style of the book such that reading becomes a pleasant task rather than a laborious means of acquiring knowledge.

The volume deals adequately with all the skin conditions that the ordinary practitioner is likely to meet, although the rarer conditions mainly of interest to the specialist are omitted. It may be recommended with confidence as a useful book for the student.

A Centenary Memoir. (Claudius Ash, Son & Co., Ltd.)

It seems at first unreasonable to ask of the ambitious man, his attention for the moment upon retrospection, that he may progress further. So it is possible that a book of past years, of the early efforts of our benefactors in their crude researches, may escape the recognition which it merits.

As an incentive though to further effort in our researches and investigations, an occasional review of the experiments and pioneer work conducted by the early investigators is extremely helpful. Of just such a help is the Centenary Memoir of C. Ash and Son.

One is reminded of the crude implements and the lack of material, which handicapped the dentist of a century ago, and one marvels to think how they persevered in their struggles to accomplish anything under such conditions.

The Memoir sketches the growth of the dental manufacturing industry from its earliest times, and naturally it is more concerned with the progress of its own firm than with that of competitive firms, but the subject matter is frank and unbiased.

It is well to read such a Memoir, in order that one may arrive at a just appreciation of the interdependence of the dental profession and the dental manufacturing industry, and of the profound results that can be obtained by their efforts in common.

Dictionary of Medical Treatment and Diet. By James Burnet, M.A., M.D., M.R.C.P.Edin. (Black's Medical Series). Pages 156. 5s. net.

There seems to be a tendency among the majority of Ward Clerks to be temporarily content, if after great mental effort they have succeeded in affixing

an appropriate name to a disease or pathological condition, and to consider that the treatment thereof is entirely the H.P.'s concern. This small and compact handbook should do much to correct that tendency. It is the second edition of a book which has been out of print for some time, and has now been thoroughly revised by the author. Great attention has been paid to nursing technique and diet throughout, and many useful prescriptions are given for common ailments which are seldom, if ever, seen in the wards. The Appendix on Diet contains the details of infant feeding, and the composition and comparative digestibility of various foods and proprietary brands.

If anything, the author has confined himself too rigidly to Medicine, to the exclusion of much which might be considered as being on the borderland between Medicine and Surgery. It was somewhat surprising to read that "appendicitis is sometimes undoubtedly of rheumatic origin, and salicylates give relief"; also that silver salts are given so little prominence in the treatment of gonorrhœa, and that no mention is made of the treatment of hæmorrhoids by carbolic acid injection.

The book should, however, be of much use to Medical Ward Clerks and Clinicals, particularly if used in conjunction with Hale-White's "Materia Medica."

Specialities.

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Pepsin	0·81%
Acid Calcium Phosphate	1·04%
Precipitated Tri-Calcium Phosphate	51·99%
Calcium Chloride	0·44%
Glycerine, Alcohol and water, flavouring, etc.	45·72%

Long and exhaustive tests have been made in the laboratories of the Pepsodent Co., which afford abundant proof that this Preparation fulfils all its claims, and merits the success which has distinguished it as one of the best Preparations obtainable.

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Death.

WILLAN.—On March 23rd. 1922, at Melton Mowbray, George Thomas Willan, M.R.C.S., L.S.A., retired. Aged 80 years.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE officials of the Labour Party have issued a statement of their policy with regard to hospitals, containing twenty closely printed pages dealing with the practices which the writers consider objectionable under the present system, and concluding with an outline of the scheme under which hospitals would be managed if the Labour ideal were attained. The final summary of their views, which embodies thirteen main recommendations, will be found by those who are interested in the subject (as most of us must be) on page 570 of the *British Medical Journal* issued on April 8th. The same issue contains a very comprehensive criticism of the views set forth in the pamphlet.

The introductory pages of the Labour Party's report contain much that appears to be legitimate criticism of existing methods, apart from a definite tendency to exaggeration. Indeed, it is evident, from the manner in which the subject is dealt with, that the writer, or writers have had considerable experience of hospital routine in this country, and that their knowledge is first-hand knowledge. If the writers are medical men who have inside knowledge of conditions in our general hospitals, as it seems they must be, the conclusions which they draw from their experiences are in many ways surprising.

In the first place, the document deplores the lack of unification of control in hospital administration, and describes the voluntary hospitals as being "each a law unto itself." The essential recommendation of the whole pamphlet is that State Control of Hospitals should be adopted, and this is suggested as a remedy for the present state of inco-ordination. But the very paragraph which deplores this lack of co-operation contains a list of different Public Authorities at present responsible for those hospitals which do come under the control of the State. As has been pointed out in the *British Medical Journal*, if the State has not yet succeeded in unifying its own system of statutory hospitals, it is not likely that the absorption of the voluntary hospitals into a State-controlled system would improve matters.

The paragraphs on "Anomalies of the Voluntary System" contain many exaggerations (as, for instance, the statement that the hospital day starts between 2 and 3 a.m., causing a continual state of unrest until about 9 a.m.), and some statements that are absolutely erroneous. In the paragraph devoted to nurses, the writers complain of the attitude of "servility" towards doctors which is required of them, and of their lack of initiative and real sympathy. In our opinion this is an entirely unjust estimate of a nurse's position. The activities of the nurse must, of necessity, be subordinated to those of the doctor, or chaos would result, and we do not agree that they are lacking in sympathy.

The real motive of the whole report is to advocate the adoption of State Control, a sys-

tem which we are convinced would lead to the stagnation which is so often observed in State-run institutions.

An indication of the propaganda which this report is attempting to disseminate is contained in the statement that public grants to Voluntary Hospitals, conditional upon efficiency, would be welcomed, as this would but be the "thin edge of the wedge," tending to complete nationalisation.

The plea for extension of the number of hospital beds per 1,000 of the population is based upon an erroneous estimate of the number of beds already available in the United Kingdom, and the proposals for obtaining increased hospital accommodation involve a cheerful indifference to the fate of the already overburdened taxpayer. It is true that increased accommodation is desirable, but this cannot be obtained by building large State Hospitals at the expense of the public, without any reference to the people who have to pay for their erection.

In short, the attitude which the pamphlet discloses is that of idealists who would have everything done for the people, but who do not realise that the methods they advocate would impose upon them a still heavier burden.

Dr. Braithwaite, in a letter to the Gazette, which appears in our correspondence columns, is inclined to make a very pessimistic estimate of the value of Welfare Centres. It is true that he is generous enough in his praise of the Salomons Centre—but who would not be? The remainder he "praises with faint damns."

We are definitely of opinion that the work performed by these Infant Welfare Centres *is* worth while; the reduction in infant mortality which has been observed since their inception is convincing enough testimony to their value. But even if one supposes that the cases quoted by Dr. Braithwaite are really representative, and that widespread abuses do exist, the fault really lies with individuals, and not with Welfare Centres as such. To the question, "Could Welfare Centres be worth while?" the only possible reply is an emphatic affirmative. An answer to Dr. Braithwaite's question, "*Are* Welfare Centres worth while?" must also be in the affirmative. Everybody is aware of the great influence for good exerted by these centres, and a criticism based upon only four cases can hardly be taken seriously, although there is no doubt that the instances quoted in Dr. Braithwaite's letter are enough proof that in Welfare Centres, as in every other field of human endeavour, perfection has not yet been attained.

No statistician, however, would dare to record four cases, one of which was treated successfully, while the remaining three suffered some degree of neglect, and then to claim these data as proof that seventy-five per cent. of cases were not treated properly! It is, therefore impossible to believe our correspondent's assertion that his cases are representative.

The election of representatives on the Council of the Royal College of Surgeons will take place on July 7th, and Guy's Fellows are once again reminded that Mr. Rowlands is a candidate for one of the vacancies, and that they should all endeavour, by supporting his candidature, to ensure that this Medical School shall obtain more adequate representation on the Council. At present Guy's is represented by only two members of the Active Staff of the Hospital.

In previous elections voters have not infrequently adopted the policy of "plumping" for one man. By this we mean that they have not used all of their votes, but have merely voted for their own candidate, ignoring their other votes. (No candidate may receive more than one vote from each Fellow.)

It has been suggested that it would be a more advantageous plan to use all votes, for different candidates. A Guy's Fellow could, having voted for the Guy's candidate, allot his remaining votes to whichever other candidates he desired to support. Fellows from other Hospitals might, by some mutual arrangement, be persuaded to vote similarly for the Guy's candidate. In this way a fairer distribution of votes would be effected, and a voter would not find it necessary to abstain from voting for candidates from other schools. At the same time additional support for his own candidate would be assured.

We have been asked to draw attention to the Annual Guy's Dance, which will be held at Prince's Restaurant on April 28th. A notice giving fuller details appears on page 158.

It should hardly be necessary, in a Hospital teeming with keen dancers, to urge students to go to this dance. It's attractions should be sufficient inducement to most people who have been before. To the many indigent and needy members of the Hospital we may point out that the tickets are cheaper (by 7s. 6d.) this year. The dance was very well attended last year. With the additional merit of comparative cheapness, its success this year should be phenomenal.

A HYPERCRITICAL friend (ignoring the April vagaries of a genial compositor) writes to inform us that the use of such an expression as "to embark upon the stormy seas of literary polemics" is inadmissible. Any Editor, who *is* an Editor, he assures us, should realise that the Greek word πολεμος means "a land-battle," and that there can be no question of "stormy seas."

We might, of course, shrug our shoulders, and point out that anybody ought to know what we meant, and that life is short—he might prefer ὁ βίος βραχύς—but it is, perhaps, more fitting to reply that the English word "polemics" may be applied to any scientific or political dispute, and that we admire his proficiency in that fine old academic pastime "Splitting the Hair."

THE letter from Mr.H. M. H. Ashwin, which we publish in this issue, raises a point we feel to be well worth considering. It is, naturally, difficult to ask members of the Staff, who have their own practices to attend to when not at the Hospital, to undertake any radical alteration of the hours at which they give lectures. But the alteration of the time of Monday lectures from 1.30 p.m. to 1 p.m. is hardly likely to cause lecturers any serious inconvenience, especially when one considers that one individual lecturer is not likely to strike a Monday very often. On the other hand, great benefit would accrue to the students if such a step were taken. As it is, a large number of men are prevented by their other duties from attending Monday lectures, whereas an alteration in time of merely half an hour would make all the difference. Apart from the question of their undoubted educational value, the fact that attendance at a large proportion of these lectures is compulsory during a student's years in the wards, makes it essential that most men should be able to attend them. And we know of men who, having had, in a series of appointments, duties at 2 p.m. on Mondays, have not been able to attend a Monday lecture for nine months.

Obituary.

THOMAS FRANKLIN PEDLEY.

As recorded in our Obituary Column Thomas Franklin Pedley, eldest son of the late George Pedley, of "The Haven," Sutton, died of heart failure in his home, Bridge House, Rangoon, Burmah, on January 13th, aged 67 years. T. F. Pedley entered Guy's in 1872, and was a contemporary of Robert Carrington, the young and brilliant physician who died at the age of 33. He was dresser to Thomas Bryant, and spent much time in the Dental Department as Assistant to Mr. Moon, then the Dental Surgeon. He took his M.R.C.S. and L.S.A. in 1876, and L.D.S. in 1877, and the M.D. of Brussels in 1879. Both before and after qualifying he showed signs of lung trouble by attacks of pleurisy and pneumonia. Sir Fredk. Taylor, the Assistant Physician, strongly urged him to live abroad, free from the fogs of London—excellent advice as the sequel proved. After twice voyaging to and from Australia as Ship's Surgeon, he finally settled in Rangoon, and but for short intervals of rest in the Hill Stations or in England, practiced there for 42 years. For some time he held the post of Medical Officer to the municipality. That appointment led to an early acquaintance with the Burmese, their language, and their ancient civilisation, and also led to that sympathetic interest he had for the people amongst whom he had found a home.

He worked to save life, with due regard for the manners and customs of his patients, and a profound reverence for the teachings of Buddha.

He published papers in the vernacular to prove the advantages of efficient sanitation to abolish plague, cholera, and tuberculosis; and of vaccination in preventing the ravages of smallpox. This latter he was able to carry out, as a public vaccinator.

With the aid of Government Officials and a few enlightened Burmese he performed, in a practical manner, the duties of M.O.H., although meeting with much opposition, and contending with difficulties unknown to such officers in Britain. He resigned in order to devote himself to private practice, and he allowed no personal considerations to interfere with this work.

To the Obstetrical Society he contributed articles on "Midwifery Methods amongst the Burmese," and to the *B.M.J.*, in 1907, a very suggestive article, illustrated from impressions taken of the mouths of Burmese and European infants on "The Rubber Teat and Deformities of the Jaws." Thoroughly acquainted with the diet of the native races in Burmah he wrote numerous pamphlets on the subject, and it was largely due to his efforts that in the British Isles "unmilled rice" known as "unpolished rice" was made popular as a nutritious article of diet during the war.

T. F. Pedley was the founder and constant supporter of the Dufferin Maternity Hospital in Rangoon, and of the Burmah branch of the St. John's Ambulance. He joined the Rangoon Port Defence Volunteers as Medical Officer in 1899, and rose to the rank of Surgeon-Lieutenant-Colonel, accompanying his contingent to the Delhi Durbar. He received the V.D. in 1899, and also held the first class gold medal of the Kaiser-i-Hind.

Mrs. Pedley predeceased her husband in 1909, but he leaves to mourn his loss one daughter, and two sons, one of whom, Chas. F. Pedley received his training at Guy's.

It is to such men as T. F. Pedley, whether in civilian life or of the official class, that we look to uphold the character of the British in the far distant lands of our Empire. By their devotion to duty, their honest integrity, and their sympathy for those amongst whom their lot is cast, they have obtained that affectionate regard and loyalty from the native races, without which our Empire in India would rapidly pass away.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

An Interesting Skin Eruption.

DEAR SIR,—I forward you five photographs of an interesting case of skin eruption, interesting for the following reasons—

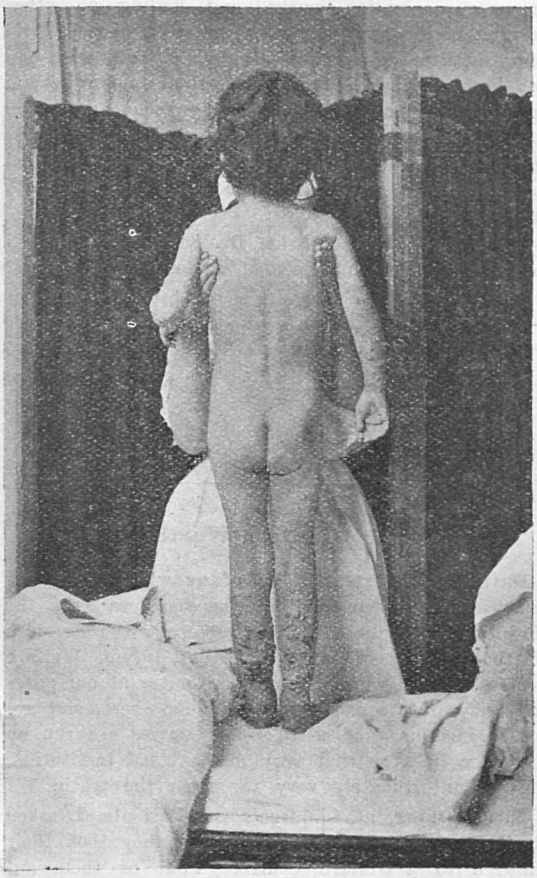
1. The distribution of the rash—symmetrical, as is shown by the photographs taken of the right and left side.

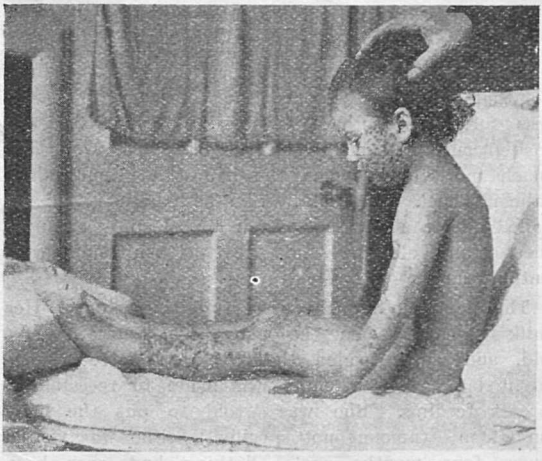
2. The absence of any rash on the trunk either front view or back view.

3. Symmetrical distribution of rash on face—one spot over each eyebrow, and no others on forehead, no spots on nose or between mouth and chin.

4. No spots on hands or feet.

History of Case.—I. H., f., æt. 7, one of family of seven, including father and mother, who all had influenza; this child had a bad attack, temperature running up to 104·6°. On the 3rd day of her illness a rose rash somewhat resembling measles appeared, and two days after the rash became vesicular and then became pustular.





The medical man under whose charge the child was, called in the Medical Officer of Health, and he, not liking the look of the rash, called in Dr. Wanklin, the small-pox specialist of the L.C.C., and after

careful examination of the child, who had four good primary vaccination marks, and finding no other member of the family affected, and that another child who had been in contact with I. H., and who had not been vaccinated, was free from any rash, and finally no case of small-pox having been reported in this district, gave as his decision that the case was not one of small-pox, or varioloid, and recommended the case to be removed to the Infirmary, Romford, and to be isolated.

Three days after admission Dr. Sequeira was asked to see the child, and decided against small-pox.

Solution.—A very severe case of bromide rash.

I am, Yours sincerely,

J. A. FRASER.

Western Lodge,
Romford.
22nd March, 1922.

Are Welfare Centres Worth While?

DEAR MR. EDITOR,—Those of us who confine our activities to working within the four walls of the Hospital are liable to form a totally wrong idea of the amount of good done by Infant Welfare Centres. We have the Salomon's Centre at our gates and know of the excellent work done there, and are apt to imagine that all Welfare Centres are run on the same lines as that very nearly ideal institution. This is unfortunately very far from the truth.

This morning, at Children's Out-Patients, I asked all the mothers who came to me if they took their children to a Welfare Centre. Four of them answered in the affirmative, and of them I obtained particulars of the ways in which these bodies helped them.

One of them was under the Salomon's Centre, and it is fitting that her story should come first, so that we can compare the experiences of the less fortunate mothers with it. Briefly, she was visited once a month when the baby was well, and much more often when the baby had some minor ailment, such as a cold. She had been given detailed advice about food, fresh air, sleeping arrangements, and clothing—and she was white-hot with enthusiasm.

The next mother gave the following story. Her milk "went" when the baby was fourteen days old, and she attended the Welfare Centre a fortnight later. No attempt was made to re-establish breast feeding. She was "told to put the baby on Glaxo" (amount not specified). She was visited once, four months ago. Nothing had ever been said about fresh air, clothing or sleeping arrangements. Every week she saw the doctor, who usually asked if the baby was sucking the bottle all right, and told her to come again next week. She volunteered the statement that she attended the Welfare Centre "because Glaxo was so cheap there."

The next mother had attended her Centre for nine months. She had never been visited. The baby was breast fed, but was now 12 months old. No advice on food had ever been given. Sleeping had not been mentioned. Once she was told to put the child in "light and warm clothing."

The last mother had attended the Centre since the baby was a month old. Her milk had "gone" a fortnight previously, but no attempt was made to bring it back. Other than a recommendation to try some particular brand of patent food, no conversation about diet had taken place—she had now been attending twelve months. Clothes had not been mentioned. She had been visited once.

These are not picked cases, they are just four taken at random from Out-Patients; but I venture to state that they are representative, that out of every four Welfare Centres, only one is really "worth while." The others are "centres," but the only "welfare" actively looked after is that of the Staffs who run them. In my opinion three out of four Welfare Centres are not worth the ratepayers' money, or the mothers' time spent on them.

I believe that the cause of this deplorable state of affairs is that the majority of medical officers to Infant Welfare Centres are chosen, not because they know something about babies and mothers, and have a sympathetic and understanding nature, but because they have a vast knowledge of lavatories, sewers, and the cultural reactions of obscure and quite unimportant bacilli—because, in fact, they possess the D.P.H. Whenever the M.O. fulfils the first-mentioned conditions, the Welfare Centre booms; if she does not (it is nearly always a "she") the Centre degenerates into a store where mothers can buy cheap patent foods, if they like to sacrifice the dummies and prepuces of their children to become members.—I am, Sir, yours faithfully,

V. BRAITHWAITE.

Guy's Hospital,
London, S.E.1.
April 5th, 1922.

Clinical Lectures.

DEAR SIR,—Would it inconvenience the surgeon or physician who is scheduled to lecture on Mondays at 1.30 p.m., if he were asked to start his lecture at 1 p.m.?

There are many of us who find it impossible to attend because of the half hour after 2 p.m. when most of us are engaged with our surgical or medical units. Between 12 noon and 1 p.m. we are

not allowed into the wards for the purpose of dressing patients or writing up cases, because the nursing staff and patients are busy with the midday meal. This amount of time would be adequate for our lunch, and the extra half hour to 1.30 p.m., is not necessary.

If this could be arranged we could join our respective units at 2 p.m., after the lecture. At the present time there are three surgical units containing 54 students in all, and two medical units containing 30 students, making a total of 84 students who are unable to attend these lectures.

Senior surgeons' dressers can make their dressing appointments in the Front Surgery from 11.30 a.m., and would have time to have lunch before 1 p.m. The only students who might be affected are the 2 dressers in the Front Surgery, the 2 "take in" dressers, the 2 "take in" ward clerks, and on some occasions those at Out-Patients, when they finish late.—I am, yours faithfully,

H. M. H. ASHWIN.

The College.
April 7th, 1922.

Thomas Franklin Pedley.

DEAR MR. EDITOR,—Permit me to add a brief personal appreciation to the obituary notice of T. F. Pedley, whose death will be long felt in Rangoon. He was one whose friendship was well worth the having; though our meetings were punctuated by long intervals, time did not prevent the return of the old cordiality. He was always the same, a true Christian gentleman spending his life for the good of others.

Of his devotion to the welfare of the Burmese I have heard from several friends, more particularly with regard to the Women's Hospital. Here and in other ways he gained their affection and at the same time the esteem of the English community, for all appreciated his lofty motives and unselfish devotion.

Pedley took up the white man's burden as a duty and laboured in every way to improve the lot of the native.—Faithfully yours. CHARTERS SYMONDS.

10th April, 1922.

Anæsthetics.

DEAR SIR,—May I be permitted to criticise the Summary of Anæsthetics, as reported in the last number of the GAZETTE?

In the first place, the only real use of statistics relating to anæsthetics is to endeavour to ascertain the relative safety of each. It is therefore, quite futile, out of a total of 8,000 odd, to group nearly 6,000, i.e., threequarters, as miscellaneous (and very much the same appears in the report for 1920). It would be far better, and would also save space, to state simply that the number of anæsthetics administered during the year was 8,094.

But there is really no difficulty in classifying administrations, so that the miscellaneous group disappears entirely. The following table shows the method I employ myself, the numbers given being entirely imaginary.

ANÆSTHETICS FOR THE YEAR 19—.

	Induction.	Sequences.	Totals.	Deaths.
1	Chloroform ...	—	123	... 1 (*a*)
2	" ...	Ether ...	731	
3	" ...	Ether: C.E.	403	2 (1 during Ether; 1 during C.E.).
4	" ...	C.E. ...	41	
5	" ...	Ethanesal ...	27	
6	Ether: open ...	—	12	
7	Ether: closed ...	—	25	
8	C.E.	—	648	1
9	"	Ether ...	169	
10	A.C.E.	— ...	5	
11	Ethyl Chloride	— ...	232	2
12	* " ...	Ether ...	19	
13	Gas	— ...	1567	
14	"	Oxygen ...	104	
		etc., etc.		

SUMMARY.

	Totals.	Deaths.
All Anæsthetics	4106	... 6
Chloroform (1, 2, 3, 4, 5) ...	1325	... 1
Ether (2, 3, 6, 7, 9, 12)... ...	1359	... 1
etc., etc		

In addition, it is essential that some brief details be given regarding deaths: e.g., (a) General peritonitis, patient admitted moribund; died during wound closure; anæsthetic—chloroform, prepared from industrial methylated spirit. In all fatal cases the exact nature of the anæsthetic should be clearly indicated, e.g., ethyl-, methylated-, or acetone-chloroform.

In the case of large general hospitals with teaching schools attached, separate returns should always be made for anæsthetics given by the staff anæsthetists, and for those otherwise administered.

If the above method was universally carried out, we should in a few years have some large figures worth quoting, instead of the vague generalities usually to be found in text books on the subject.—I am, yours faithfully,

H. GRANTHAM DODD.

Hon. Anæsthetist Hove Hospital; Royal Alexandra Hospital, Brighton, etc.

April 4th, 1922.

Change of Address.

C. C. Bennett, 27, Gay Street, Bath.

N. N. A. Houghton, 16, Beech House Road, Croydon.

A Neurological Case lately under the care of Dr. Symonds.

G. C., aged 45, was admitted for pain in the right arm. He first had intermittent pain in his right biceps last November, which, however, passed off. In March of this year he had a recurrence of pain starting between the shoulder blades and radiating down the dorsal aspect of the arm to the elbow and thence down the outer ridge of the forearm to the tips of all the fingers. The pain is almost continuous and is of a gnawing, crushing nature. He has also had indefinite pains in his legs, as if something were crawling up them; they only last a few seconds. The patient is an unreliable witness and is very prone to exaggerate. He says that the pain considerably interferes with his sleep. There are a few fine râles at both apices. His C.N.S. appears to be normal. On jolting his head or feet he cries out with pain in the region described, and also in the region of the second dorsal vertebra; pressure on this vertebra elicits no pain.

There appear to be several possibilities as to diagnosis, amongst which may be mentioned:—

1. Tabes Dorsalis.
2. Spinal Caries.
3. An Intrathecal Tumour.
4. Meningitis.
5. Brachial Neuritis.
6. Cervical Rib.
7. Secondary Deposits.
8. Functional Neurosis.

In each instance there appear to be several objections.

1. *Tabes Dorsalis.*—There are no other signs of it, his C.N.S. appears to be normal. His Wassermann is negative, both in blood and C.S.F.

2. *Spinal Caries.*—There is no wasting or rigidity of muscles; no tenderness. X-ray is negative.

3. *Intrathecal Tumour.*—The distribution of the pain is much too widespread; at least five nerve roots must be affected. A hæmatoma is but a form of tumour.

4. *Meningitis.*—Here the area affected is surprisingly localised; the pain being unilateral. One would also expect other signs, e.g., motor signs, paralyses, muscular wasting. There is no reason to believe the meningitis to be syphilitic; it might be tuberculous; e.g., localised tuberculous pachymeningitis, without caries. There is no history of trauma.

5. *Brachial Neuritis*—of the Sciatic type.—There is no muscular wasting and the reflexes appear normal.

6. *Cervical Rib.*—The distribution of the pain between the shoulders is atypical and there is no numbness or tingling of the fingers.

7. *Secondary Deposits.*—The same objections hold good here as for an intrathecal tumour.

8. *Functional Neurosis.*—The patient's symptoms appear very real and his sleep is interfered with. The onset was too gradual to be typically hysterical; on the other hand his symptoms do not fit in with any other diagnosis.

Parasites, such as the echinococcus and cysticercus may occur in the spinal cord; but to these there are many objections besides their rarity.

I am indebted to Dr. Symonds and Mr. Laver for permission to publish this case.

F. E. GRAHAM-BONNALIE.

Pass List.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES. PART I.
March, 1922.

E. H. J. Berry.	F. H. K. Knight.
L. R. B. Birt.	W. Leslie.
D. C. McC. Ettles.	J. W. Schollum.
C. A. N. Hicks.	A. F. W. H. Stewart.
M. E. M. Jago.	W. S. Whimster.

SECOND EXAMINATION FOR MEDICAL DEGREES. PART II.
March, 1922.

C. B. Andreae.	Barney Kessel.
I. M. Benjamin.	Howel Lewis.
P. C. Bennison.	G. A. Martin.
H. E. Blake.	F. C. Miller.
M. F. Butler.	A. B. Plant.
G. Davies.	W. G. Roberts.
L. Davies.	W. F. Roper.
S. C. Davison.	F. W. Schofield.
†G. R. Ford.	H. J. Selby.
T. M. Fripp.	G. P. Spurrell.
H. G. Fuller.	L. A. S. Trott.
A. S. Gough.	R. L. Waterfield.
D. S. Huskisson.	R. G. Williams.
R. M. Jones.	J. C. Young.

†Distinguished in Physiology.

Diploma in Psychological Medicine.

Part I.

Allen C. Hancock.

Diploma in Tropical Medicine & Hygiene of the Conjoint Board.

W. H. Grace.

Society of Apothecaries of London.

March, 1922.

Forensic Medicine.

C. F. Parry.

Midwifery.

C. A. Marais.

Acute Intestinal Obstruction.

CLINICAL LECTURE BY MR. R. P. ROWLANDS.

GENTLEMEN,—Intestinal obstruction is a very grave emergency, for without early operation it almost always leads to death. Exceptions are so few and delay has proved so disastrous that an operation is now generally regarded as the only reasonable treatment in the large majority of cases. At the present time the mortality of operations for this condition is about 50 per cent., but, with more prompt action, there is no reason why it should be above 10 per cent. That delay is the main cause of failure is shown by the brilliant success of *early* operation. Serious damage to the bowel takes time to develop. Every hour wasted makes the condition a little worse and adds to the formation and absorption of toxins; the difficulties and length of the operation are increased and also the amount of anæsthetic required, which is extremely detrimental for the subjects of acute intestinal obstruction.

Unfortunately, valuable time is all too frequently lost before arriving at a diagnosis. Sedatives, given for the relief of pain, mask the symptoms. It is humane to give a single dose of morphia, but it is unwise to repeat it for, by lessening the pain, it obscures Nature's urgent call for relief. Also, too much faith is placed in purgatives. A single dose, by failing to act and increasing symptoms, sometimes assists in the diagnosis, but repeated doses damage the intestines at or above the obstruction. Peristalsis of the upper part of the bowel is increased, causing inflammation and distension of the lower part, with mechanical injury at the site of obstruction. Repeated enemata are less harmful and may even serve to overcome obstruction of the large bowel due to cancer or volvulus, thus allowing the patient to be subsequently cured by one instead of several operations.

CASE 1.

Obstruction of Small Intestine by a Band.—The patient, a fine little boy, aged 6, had been very well until the evening of the 18th, when he was seized with pain in the abdomen and a great desire to empty the bowel. However, although there was a free action, the pain remained. The bowels were not opened again except for a few scybala, the result of repeated enemata. The doctor was asked to see him on the 20th. His temperature was then normal and his pulse hardly accelerated, but he was clearly in a great deal of pain. He was sick twice on the 19th, but not afterwards. He had taken only fluids (about 1 pint a day). The temperature had never been raised, but the abdomen had gradually got more distended. I saw him at 7.30 p.m. on the 22nd. A swelling which varied in hardness had been felt in the right lumbar region. ? intussusception. The absence of any blood or slime, however, made that improbable, and a band was the alternative diagnosis. There was no definite history of a previous attack of appendicitis, but the child had had a hernia on the right side as a baby. A band due to tuberculous peritonitis was considered. The abdomen was hugely distended, but not very tender or rigid. The boy did not look very ill, but his pulse was 130 and his temperature normal. The pain was better. He clearly had a great deal of free fluid in the abdomen. The latter was opened through the middle third of the rectus; a large amount of clear fluid escaped, and the obstruction was at once felt high in the right iliac region. It consisted of a broad band which was running across a piece of ileum and completely obstructing it. It passed from the side of one piece of intestine to a large caseous mesenteric gland, which was adherent to the right flank. A finger was hooked under it and the band was clamped, divided and tied. An attempt was made to dissect out the caseous gland, but this was found to be impossible. It was, therefore, well surrounded with packing and opened. Caseous fluid immediately escaped. This was mopped away, the greater part of the capsule of the gland cut away, and the remainder carefully sewn over with catgut. The band had not damaged the bowel seriously at the point of contraction, but the intestine above was very considerably distended, and also there were some hæmorrhages in its wall. Still, it was thought wiser not to drain the bowel. Meanwhile, a gauze wick which had been passed towards the pelvis had absorbed most of the liquid. There was some difficulty in closing the abdomen owing to the flatulent distension. The operation lasted half-an-hour. Immediately the child was put back to bed the stomach was washed out, for he had been sick during the anæsthetic and had brought up some brown vomit. He was infused into the axillæ, one pint being run into each. The boy made a good recovery.

CASE 2.

Strangulation of a Loop of Small Intestine by a Band.—The patient, a man aged 54, said that he had been quite well until three days previously, when he was suddenly seized at 3 a.m. with the most violent abdominal pain. Since then he had been persistently sick and in great pain. He had hardly slept. Lately the vomit had become offensive, and it was thin and brown, suggestive of obstruction of the small intestine. The abdomen was moderately distended in the middle line, and peristalsis could be seen in coils of the small intestine. At the operation an incision was made to the left of the middle line below the umbilicus. The colon was empty. The small intestine was deeply congested and distended. A band was felt extending from the appendix to the great omentum, and under this a loop of ileum, 12 inches long, was strangulated. The peritoneum of the bowel about this point had been scraped away by movement under the sharp band. This was divided with the fingers and the bowel was brought out and examined. It was shiny, though deeply congested, and quite rigid, and hard in places, but it was thought to be recoverable and returned. The mesentery, although œdematous, pulsated well. Before the operation the stomach had been washed out, one pint of offensive fluid coming away. The patient did very well.

CASE 3.

Strangulation of a Loop of Small Intestine by a Band. Gangrene. Resection. Recovery.—Patient, a man of 23, had had no previous illnesses. Three days before admission into hospital he was seized with violent pain in the left flank which later spread forward to the left side of the lower abdomen. The bowels had been opened that morning, but not since. The pain was very violent, so that he had not slept at all, but kept vomiting at frequent intervals. Pain and vomiting, however, abated after he came into hospital, and it was not considered necessary to operate at once. The temperature and respiration were normal, pulse 80, but the abdomen was too full especially in the lower part. It did not move well, and was tender low down and to the left of the middle line, where there was some resistance. Two enemata had acted slightly; urine was normal. When I saw the patient at 2 p.m. I concluded there was intestinal obstruction, probably of the small intestine by a band, and that there was secondary inflammation developing. He was clearly very ill, and an operation was urgently necessary.

Operation.—A left paramedian valvular incision. A band gave way on examining a swelling in the pelvis. This swelling was brought up, and proved to be a gangrenous loop of the small intestine, 6 inches long, surrounded by adherent coils of the small intestine. The loop was yellowish-black and covered with lymph, but it had not perforated. At its two ends there were constrictions where the band had been. The bowel above was considerably dilated, and that below was inflamed and moderately dilated and adherent to the gangrenous loop. The adhesions were separated and the gangrenous part packed off, while a lateral anastomosis was made between the ileum, 6 inches above and 4 inches below the gangrenous loop. The latter was excised, its mesentery tied with catgut and the stumps also tied with catgut and then invaginated with two purse-string sutures of fine linen thread. Linen thread was also used for the anastomosis. Care was taken to avoid leaving pouches of bowel near the lateral anastomosis, for these often enlarge and cause pain and other symptoms. There was only local peritonitis. The bowels opened spontaneously that night. The patient rapidly recovered.

CASE 4.

Obstruction of the Transverse Colon by a Band. Death.—The patient, who was a stout man, aged 53, was admitted to Guy's in the afternoon of the 31st August, 1912, for hiccough and abdominal pain and distension. On the 24th he ran after two boys who were stealing his apples, caught them and carried them in his arms, telling them he was going to give them to his big dog. Just then he was seized with violent abdominal pain and let the boys go. He and his relations thought his illness was a judgment for frightening the boys. He was so very collapsed afterwards that a consulting physician was called in by his doctor to see him. It was thought that he had injured the valve of his heart. The pain was in the left hypochondrium, but later it extended downwards towards the middle line and below the navel. Since then the abdomen had gradually become more painful and distended. The temperature was said to have been a little raised. He had been sick only once. The physician went to see him again on the

30th and washed out his stomach and colon, and though the bowels were said to have acted well then, the distension did not diminish materially and had increased since. The patient was therefore admitted into hospital for exploration. Pneumonia had been suggested as a diagnosis; also pneumococcal peritonitis. When I saw him his abdomen was enormously distended, but not tender. He was a little dull in the right flank. On palpation a gurgling noise could be heard in the right hypochondrium, and the patient said this was a common occurrence. The pulse was only 100, the temperature normal, respiration rather quick, and there were a few râles at the base of the lungs. The rectum was normal. There was no marked tenderness anywhere. Some form of internal hernia, with incomplete obstruction, was considered probable. Appendicitis was also considered. Perforation of a gastric ulcer was negatived by the long history and the absence of any history of indigestion.

Operation.—On 31st August, 1912, A.C.E. was given and the abdomen was opened a little to the right of the middle line. There was no free fluid. The transverse colon was at once seen to be enormously distended. The hand was passed to the sigmoid and this was found to be full of gas, but the descending colon was empty and very fat and nodular, but not hard. The appendix was adherent and contained calculi, but it was not inflamed. The gall-bladder region was normal. The site of obstruction could not be found until the transverse colon was drawn out of the abdomen and to the right, and then a band was found running in front and below the transverse colon close to the splenic flexure. This was divided and then a deep constriction was noticed on the colon, the serous membrane being lacerated on the front and lower border of the bowel. Immediately the band was divided the distension diminished and the descending colon became blown out. A rectal tube was introduced and a large amount of gas escaped, so that it became quite easy to close the abdomen. Axillary infusion was given after the operation, also pituitary extract. Although his bowels acted freely, the patient died on the morning of September 3rd, muttering that his tragic end was the judgment of God.

Case 5.

Volvulus of Pelvic Colon. Colostomy twice for this, and later for Carcinoma.—An old lady of 61, after repeated attacks of obstruction, with enormous distension of the abdomen, was operated upon. The colon was so enormously distended that the surgeon accidentally opened it, causing a loud report. A colotomy tube was left in the sigmoid, and a diagnosis of cancer of the pelvic colon was made, but the colostomy closed after six weeks and the patient was fairly well for six years, passing no blood or mucus. The symptoms recurred at intervals and at last became very acute, demanding another operation. The volvulus of the pelvic colon was untwisted, after letting out gas from the enormous loop which reached up to the right lobe of the liver. The colostomy was repeated and soon closed, and the patient was well for four years. Then she became obstructed again and colostomy was performed for the third time in ten years, but on this occasion the cause of the obstruction was carcinoma of the rectum. She survived for two years after her last operation. This case was published in full in Jacobson's "Operations of Surgery," vol. ii.

In cases of acute intestinal obstruction our endeavours should be directed towards arriving at a correct diagnosis earlier, and then to impress upon everyone concerned that an immediate operation is imperative, and lastly, to perfect our operations and after-treatment. To facilitate diagnosis, attention may be drawn to the most important symptoms and signs.

Symptoms and Signs.

(a) *Pain.*—The initial pain of acute intestinal obstruction is usually severe, and is referred to the umbilicus. When the obstruction is in the small intestine there is often great pain in the back. Later the abdominal pain is of a colicky nature, and it is often accompanied by visible peristalsis, and followed by vomiting.

(b) *Collapse.*—The patient remains somewhat collapsed throughout, his face being pale and pinched. The temperature is subnormal in the early and important stages, but towards the end it may be raised from septic infection.

(c) *Vomiting.*—The vomiting due to obstruction, especially of the small intestine, is persistent and intractable. It is only temporarily relieved by starvation or even by washing out the stomach. The vomit gradually becomes brown and offensive.

(d) *Constipation.*—The constipation is absolute, both for fæces and flatus. This statement needs a certain amount of qualification. Large enemata may bring away a good deal of fæces from the bowel below the obstruction, especially if the latter is high up in the small intestine. Again, the bowels may act fairly well or there may be diarrhœa with Richter's variety of strangulated hernia, in which the bowel is completely obstructed.

(e) *Peristalsis.*—This, when seen, is of great importance, but it may not be visible with very acute obstruction high up in the small intestine, especially if the abdominal wall is very thick. Very late in obstruction it may cease. Normal peristalsis may be seen through a very thin abdominal wall.

(f) *Quickening pulse.*—Although at first the pulse is slow and weak, later it invariably becomes quick and feeble. A quickening pulse is of the gravest significance. It must not be forgotten that all the symptoms may be minimised by starvation or masked by the administration of sedatives, especially morphia. There is often a misleading lull due to natural exhaustion. Very soon, however, the symptoms return in an aggravated form, and rapidly lead to a fatal result.

(g) *Thirst.*—The thirst that usually accompanies intestinal obstruction, especially of the small intestine, is very severe.

(h) *Insomnia.*—The subject of intestinal obstruction hardly sleeps at all until the obstruction is relieved, unless morphia is given. The administration of morphia *for abdominal pain of uncertain origin* is to be most strongly condemned, for it masks nearly all the symptoms, and therefore delays diagnosis and treatment.

(i) *Distension.*—Gradually the abdomen becomes more distended, yet supple, and moving on respiration.

Of all the symptoms complete constipation is the most important. As a rule, the patient has already taken a purgative before calling his doctor. It is not wise to give repeated purgatives, which, failing to act, increase vomiting and collapse, and considerably reduce the chances of recovery of the bowel after operation. One of the worst purgatives to repeat is calomel, which may become a powerful irritant poison. I have known the repeated administration of calomel, in small doses, lead to ulcerative colitis. Repeated large enemata are much safer, and they give all the information that we require. When the diagnosis is made, or even strongly suspected, the patient's only chance lies in an operation performed at the earliest possible moment. Nowhere is delay more disastrous.

Diagnosis.—We have firstly to diagnose intestinal obstruction from other diseases which simulate it, and secondly, if time permits, we may attempt to ascertain the variety and situation of the obstruction.

1. Diagnosis of Intestinal Obstruction from other Diseases.

The essential thing in diagnosis is to decide quickly, yet carefully, whether the symptoms are such as to make an early exploration necessary or not. A careful study of the history, signs, and symptoms, will generally lead to a correct conclusion, but there may be many difficulties. All inflammatory diseases of the abdomen are distinguished by fever, although the temperature may be subnormal soon after the perforation of a viscus, or the rupture of an abscess into the peritoneum. Rigidity and tenderness of the abdomen, either local or diffuse, are important indications of local or diffuse peritonitis. Acute *hæmorrhagic pancreatitis* is often mistaken for intestinal obstruction. The patient, who is often stout and past middle age, is groaning with pain and is of a leaden colour. Pain, tenderness, and swelling are most marked in the epigastrium. Fatty stools result from repeated large enemata, showing that true intestinal obstruction is not present. Moreover, the temperature is often raised, and the patient cyanosed. Constipation is rarely complete. Ruptured tubal gestation is characterised by the increasing pallor, the lowered blood count, the more rapid quickening of the pulse rate and the peculiar doughiness of the distending abdomen. The history and examination of the uterus and the breasts are often valuable.

The best treatment for these conditions is immediate operation, therefore difficulty in deciding between them and intestinal obstruction is no excuse for delaying exploration. Acute gastritis may sometimes give rise to difficulties, but the vomit is not intestinal and constipation is not complete. The general symptoms are not so severe as those of intestinal obstruction. The various colics may give rise to diffi-

culties, but with them, although the temperature is often subnormal, constipation is not complete, nor is the vomit brown and offensive. A purgative or an enema may act and flatus is often passed. With biliary colic there may be jaundice, or a history of previous attacks. Usually biliary colic is due to the impaction of a stone in the cystic duct. Then there are tenderness, rigidity, and often a swelling in the right hypochondrium, and a raised temperature. With renal colic the pain is limited to one flank along the course of the ureter; there are blood corpuscles in the urine, with frequency of micturition; and cystoscopy, after the intramuscular injection of indigo-carmine, shows no coloured urine issuing from one ureter. The blue line of lead poisoning may suggest the cause of colic. It must not be forgotten, however, that the presence of a lead line does not exclude more serious disease. I remember two cases in which the discovery of a lead line let to disastrous delay in opening the abdomen. In one case a perforated duodenal ulcer was temporarily overlooked, and, in the other, obstruction by bands. In both of these the delayed operation failed to save life. Lead colic is rarely severe enough to keep the patient awake all night, nor is it associated with persistent vomiting. Moreover, repeated enemata are effectual.

The vomiting due to cerebral disease may be misleading, but in this condition the abdomen is generally carinated, enemata act and there are other signs of the cerebral condition.

2. Diagnosis of the Variety of Intestinal Obstruction.

I shall begin with a classification which I find to be useful, for want of thought is a more common source of error than want of knowledge. How often do we have to admit that "we never thought of that"? In many cases, if time permits, it is possible to arrive at a fairly accurate diagnosis of the nature of the obstruction before the abdomen is opened. This is sometimes of great value, for it enables us to consider the various steps of the operation and to anticipate some of the difficulties that we may encounter. In this way the duration of the operation may be diminished, and it is certain that in this condition quickness is more important than anything except judicious and careful work. Roughly the causes of obstruction may be divided into:—

1. Pressure on the bowel from outside.

2. Disease of the wall of the bowel.

3. Foreign bodies in the bowel.

This rough classification may be amplified, as follows:—

1. *Pressure on the bowel.*

(a) External hernia.

(b) Bands and adhesions following appendicitis, tuberculous peritonitis, pelvic peritonitis (especially due to tubal disease), diverticulitis in which the appendices epiploicæ may form bands, Meckel's, gastric or duodenal perforation, and operation cholecystitis.

(c) Internal hernia through a foramen in the omentum, mesentery, or diaphragm, into the duodenal or retro-cæcal fossæ or into the foramen of Winslow.

(d) Contraction of the mesentery from tuberculous or malignant disease.

2. *Disease of the wall of the bowel.*

(a) Intussusception.

(b) Volvulus.

(c) Kink.

(d) Stricture, malignant and simple, tuberculous, after operation, after strangulated hernia.

(e) Paralysis of the bowel, especially after peritonitis; or due to thrombosis or embolism of the mesenteric vessels.

3. *Foreign bodies inside the bowel.*

(a) Gall-stones.

(b) Enteroliths.

(c) Actual foreign bodies, such as hair balls, mostly in lunatics.

As a general rule obstructions of the small intestine are acute, whereas those of the large are chronic; but there are important exceptions. For instance, strictures of the small intestine (which are rarly malignant) give rise to chronic obstruction terminating in acute obstruction. Again, volvulus of the sigmoid colon gives rise to very acute symptoms, and intussusception, which mostly affects the ileo-cæcal region, nearly always gives rise to acute obstruction. A strangulated hernia is placed first on the list because it is so often overlooked. False modesty in the examination of a nun led to the overlooking of a small strangulated femoral

hernia, which was only discovered when the abdomen had been opened. It should be the rule in every case of suspected intestinal obstruction for all the hernial orifices to be systematically examined. This is all the more important because the patient may have a hernia without any knowledge of it, and the initial pain of strangulated hernia is abdominal and not localised at the hernial orifice. Femoral hernia is the most common to be overlooked because it is often small. Obturator hernia is fortunately very rare, but when it does occur it is usually overlooked. A slight fulness below the spine of the pubes, associated with pain along the inner side of the thigh, should always lead to a careful examination of the inner aspect of the obturator canal through the rectum or vagina. It may be superfluous to say that a careful rectal examination is indicated in all cases of intestinal obstruction. In this way unsuspected carcinoma, gall-stone, or enterolith may be discovered. In one case I was able to avoid an operation for intestinal obstruction by examining the rectum of a little boy, and discovering an enterolith just within reach of the finger when the patient was sitting up and straining. His abdomen was enormously distended. The enterolith was broken up under an anæsthetic, and the patient was discharged well three days later.

Bands mostly choose the small intestine, especially the lower end of the ileum. Acute obstruction is, therefore, very likely to be due to a band, especially if distension of the colon is not indicated by bulging of the flanks, and if the distension is mainly in the middle of the abdomen, where several visible coils of small intestine with peristalsis may be seen. A history of peritonitis, and especially of appendicitis, strongly suggests a band. When the distension is slight and only one or two coils are seen, and when the vomiting is very frequent and only bilious instead of brown, the obstruction is probably in the upper part of the small intestine. A very scanty urine also suggests the same.

Kinks.—Apart from adhesions or contraction, a kink is a rare cause of intestinal obstruction, It not uncommonly results from adhesions about the hepatic flexure, and it sometimes occurs above contraction or tumours of the mesentery. It follows adhesions after operation, and especially during peritonitis, where it is mistakenly called paralytic distension of the bowel, and therefore remains unrevealed until death.

Gall-Stones.—A gall-stone usually gets impacted in the lower ileum, where the bowel is narrowest. It is curious how rarely it is diagnosed. As a rule, the diagnosis of obstruction is delayed until a successful issue is impossible. These facts may be explained by the callousness which has been bred by repeated attacks of pain due to gall-stones. As a rule there is a history of one of these attacks within about ten days of the onset of intestinal obstruction. With this attack there are signs of localised peritonitis in the right hypochondrium, indicating the formation of a fistula between the gall-bladder and the duodenum. A small or large gall-stone may escape directly from the gall-bladder into the colon and become impacted in the narrow pelvic colon, where it may closely mimic the acute symptoms of carcinoma in this situation.

Malignant Stricture of the large intestine is indicated by the characteristic history of chronic obstruction and wasting, anæmia, indigestion, constipation, alternating with diarrhœa, and the passage of blood and mucus when the ulcerating growth is low down. There is often a history of several milder attacks of acute obstruction. In some of these cases the early signs are slight or pass unnoticed so that acute intestinal obstruction appears to be the first evidence of disease.

Treatment.—The operation for acute intestinal obstruction should be undertaken as early and completed as quickly as possible, for the mortality varies directly with the delay before and the length of time consumed at the operation. No condition calls for more judgment, skill, care and speed on the part of the surgeon. In all severe cases the stomach should be emptied a little before the operation is commenced. Sometimes large drinks of Sod. Bicarb. solution suffice, but the stomach tube must be used if the case is a bad one. If the stomach is not emptied beforehand there is grave risk of suffocation from the aspiration of vomit during the operation.

A right paramedian incision, 5 inches long, is made, one-third of it above and two-thirds below the umbilicus, the rectus muscle is displaced outwards, and an opening is made in the peritoneum just sufficiently large to admit the hand for exploration without risk of prolapse of the distended intestines. The cæcum is felt and, if empty, the obstruction is in the small intestine, so the collapsed ileum is followed up to the site of obstruction. If

the cæcum is distended the hand is passed over to the pelvic colon where the obstruction may be felt. If the pelvic colon is empty the hand is passed up, along the descending colon, until the obstruction is found. Unless the condition of the patient is very grave the cause of obstruction should be found, and also removed, if this can be done without undue risk. It is only in the most serious cases that it is justifiable to be content with draining a distended loop of bowel, for the undiscovered or unremoved cause of obstruction may lead to death in spite of drainage. For instance, it is clearly wrong to leave a constricting band undivided, an intussusception or volvulus unreduced, a gangrenous loop of bowel, or a gall-stone impacted in the ileum, to lead to perforative peritonitis later on.

Bands are most common in the lower part of the abdomen, especially on the right side and in the pelvis. If none of these causes are discovered obturator and all forms of internal hernia (not forgetting diaphragmatic) should be sought. In some cases the hand, feeling patiently in the abdomen, utterly fails to find the cause of the obstruction. Under these circumstances it is necessary to withdraw a distended loop and trace it down to the seat of trouble. It is important, however, to prevent undue evisceration and to return the bowel into the abdomen as soon as possible. Most bands only need division, or, if long, excision. If the appendix or Meckel's diverticulum forms a part of the band it must be removed. A kink can be undone by separating adhesions. Volvulus, if greatly distended, may be difficult to untwist without letting out gas by means of a needle or a trochar with rubber tube attached. The opening then made is closed with a purse-string suture or, in bad cases, the bowel is drained by a rubber tube for some days. Intussusception must be reduced or, failing this, excised. It is unnecessary to excise a simple stricture of the bowel, short-circuit being much easier and safer. It is hardly ever right to excise a growth of the colon in the presence of acute obstruction, for the mortality under these circumstances is over 90 per cent. It is better to drain the bowel by cæcostomy, colostomy or short-circuit, and to perform secondary resection if possible later on. Small areas of gangrene of the bowel can be invaginated, and a narrow ring of gangrene can be similarly treated with advantage. Unless the bowel above the obstruction is greatly distended this plan is far safer than resection, which has a mortality of about 40 per cent. under these circumstances. It is, however, necessary to resect a gangrenous loop and to perform an anastomosis, either end-to-end or lateral, as may be safest. It is of the greatest importance to realise that it is absolutely essential to drain away the poisonous contents of the distended bowel. In early cases, without paralysis of the muscular wall, it is sufficient to remove the obstruction, for the natural peristalsis serves the purpose. In late cases, with paralytic distension, drainage along the natural channel, even when the organic obstruction is removed, is tardy and inefficient so that the poisoning and distension may continue.

The best method of drainage in these cases is to perform an enterostomy, fixing a small rubber tube (the size of a No. 16 catheter with several openings near its end), in the bowel after Witzel's method of gastrostomy. The suture fixing the tube to the edges of the wound in the bowel is tied with a slip knot the ends of which are left long and projecting out of the abdominal wound so that the knot can be undone and the tube withdrawn at will, 24 hours after vomiting has entirely ceased. Under these circumstances the inverted edges of the wound in the bowel usually close spontaneously, thus avoiding a subsequent operation to close the fistula and the wasting, irritation and dangers usually associated with enterostomy. I think this plan is usually much better than making an anastomosis between the distended small intestine and the colon. A rubber tube is preferable to a glass one for it is so much softer that it does not lead to the sloughing of the edges, with leakage, which so often follows the use of glass tubes. A larger tube than the one described is generally required for the cæcum or colon, on account of the thicker consistency of their contents. The temporary drainage established by an enterostomy of this kind makes an enterectomy with anastomosis of the bowel very much safer, and it also makes safer the return of distended, damaged bowel when resection is avoided. When the tube has been fixed in the bowel the loop is replaced and the abdomen and parietal wound closed snugly around it. It is unnecessary and even bad surgery to keep the loop outside for this would prevent the spontaneous closure of the fistula, when it is no longer necessary.

Appointments.

Guy's Hospital Medical School.

STUDENTS' APPOINTMENTS.

April 16th—July 15th, 1922.

Clerks to Medical Units (second three months).—(Dr. Fawcett) Messrs. J. F. Goodenough, I. M. Hurwitz, R. Macintosh, H. Maclachlan, F. Marsh, O. G. Morris, L. E. Owen, D. S. Todd-White, G. R. Vermooten, E. Wornum, S. C. H. Worseldine; (Dr. French) Messrs. E. N. C. Annis, H. M. H. Ashwin, W. H. Bradfield, A. S. M. Douglas, C. W. Greenway, J. C. Hewetson, G. C. Hughes, S. P. Jacobson, R. E. Lane, S. A. Leader, C. H. C. Toussaint; (Dr. Hurst) Messrs. D. H. Berry, L. W. Cann, R. J. Cann, R. S. Chambers, H. G. Close, J. C. G. Dickinson, R. D. Gross, C. Ive, J. L. Le C. Walker, H. D. Wyse.

Dressers to Surgical Units (Senior Dressers).—(Sir Alfred Fripp) Messrs. A. B. Davies, E. F. Gibberd, D. J. T. Jeans, J. Jemson, C. E. Keast, D. Vaughan; (Mr. Steward) Messrs. W. A. Caldwell, W. H. Craib, P. Mc G. Moffatt, M. Myers, E. E. Neser, F. N. Newell-Roberts; (Mr. Fagge) Messrs. E. R. Boland, Emrys Jones, G. O. Mitchell, G. W. V. Parry, S. C. Rowbotham, T. A. Shaw; (Mr. Rowlands) Messrs. T. S. Blacklidge, J. A. Currie, G. T. Henderson, L. G. Housden, G. C. Millis, A. T. W. Powell, H. C. C. Taylor.

(Junior Dressers).—(Mr. Turner) Messrs. C. S. Hallpike, A. I. Jowell, J. J. Laws, N. W. Mackeith, M. Taylor, R. L. Waterfield, H. J. W. J. Westlake; (Mr. Hughes) Messrs. P. S. Court, C. G. Hallpike, E. F. Hewlitt, F. Martin, K. O. Parsons, M. Rubinstein, W. R. Spurrell, A. Tom; (Mr. Davies-Colley) Messrs. H. N. Hearle, W. S. Hunt, E. I. Liberman, R. D. Owen, R. E. Robinson, E. C. Seward, H. C. Warner; (Mr. Bromley) Messrs. W. H. Bradley, A. Canard, R. B. Fawles, R. A. Grant, A. H. Jowell, J. J. Lewinstein; (Mr. Slesinger) Messrs. J. G. Jacobsz, T. G. W. Parry, O. F. A. Krause.

Obstetric Dressers and Externs.—(Mr. Bellingham Smith) Messrs. R. H. Amm, H. P. Baylis, H. L. Bernstein, N. L. Eckhoff, J. L. Faull, M. Hawke, M. Killard-Leavey, N. L. Lloyd, M. Mitman, H. Seelenfreund, G. D. Shaw, T. Wooldridge; (Mr. Chapple) Messrs. A. B. Aldred, M. Bannounnah, C. G. Bowen, R. Brooke, H. G. R. Canning, G. E. Graham-Bonnalie, D. B. Hitchings, D. G. Robinson, R. G. Tame, C. W. Warne, M. Weinbren, G. B. Withers.

Clerks and Dressers in Special Departments—

Ophthalmology.—(Mr. Eason) Messrs. G. R. M. Apsey, J. Atkin, S. C. Bakhle, L. Forman' A. W. Hall, J. T. Linklater, M. Markiles, C. C. Po, F. R. Ratnagar, D. B. Whitlock; (Mr. Ormond) Messrs. C. H. Atkinson, V. R. de Boissiere, F. J. Biddle, D. S. Davies, G. E. Fisher, M. Jackson, E. H. Koerner, G. M. Stoker, H. J. F. Wood.

Laryngology.—(Mr. Mollison) Messrs. C. H. Atkinson, F. J. Biddle, V. R. de Boissiere, D. S. Davies, G. E. Fisher, R. J. Hooker, M. Jackson, E. H. Koerner, A. F. Percy, G. M. Stoker, H. J. F. Wood; (Mr. Layton) Messrs. G. R. M. Apsey, J. Atkin, S. C. Bakhle, L. Forman, A. W. Hall, J. T. Linklater, M. Markiles, C. C. Po, F. R. Ratnagar, D. B. Whitlock.

Genito-Urinary.—Messrs. W. G. R. Hore, R. G. Sedgwick.

Neurology.—Mr. W. G. R. Hore.

Fractures.—Messrs. R. Hale-White, F. D. Howitt.

Orthopædics.—Mr. D. G. Sharp.

Dermatology.—Messrs. W. A. Brown, J. H. M. Lloyd, H. C. Meathrel, D. A. Windemer, J. L. Woodhouse.

Clinical Assistants.—Messrs. J. S. Hudson, C. L. Kark, W. M. Ramsden, H. Richards, F. W. Widgery.

Assistants to the Demonstrators of Morbid Anatomy.—Messrs. A. S. M. Douglas, J. L. Le C. Walker.

W. H. Grace, B.Sc., M.B., B.S., M.R.C.P., to be Honorary Pathologist and Honorary Assistant Physician to the Chester Royal Infirmary.

Guy's Hospital Dental School.

April—July, 1922.

House Surgeons.

Messrs. D. A. Parsons, J. D. Percy-Roberts, S. Masey, G. B. Kempster, J. F. Pilbeam (Children).

Assistant House Surgeons.

Messrs. K. Hooper, J. S. Dick, R. Van Geuns, L. B. Helder, F. A. Nicolai (Children).

Clinical Assistants.

Messrs. C. D. Farris, S. E. Lewis, L. B. Osborne, C. T. Pomeroy.

Full Surgeons' Dressers.

April—June, 1922.

Mr. Hopson.—Messrs. W. O. Bailey, C. P. C. Sargent, C. V. T. Baugh, D. R. P. Walther, J. U. Human, B. R. Moore, E. H. L. Sander, D. J. Stofberg, L. N. Theron, V. St. J. Alexander, G. Beamish, N. S. Campbell, I. S. de V. Du Toit, A. V. Goodson, W. J. Hide, H. F. Miles, J. R. Palfrey, K. G. Sharvill, H. Slater, H. G. Ryder.

Mr. Parfitt.—Messrs. J. E. Jones, C. H. Edney, J. F. Allin, D. W. C. Northfield, E. L. Sprong, J. E. B. Smith, H. Wayman, W. J. Williams, C. B. Wilson, O. H. M. Woodbridge, A. E. Nelson, G. T. Thompson, G. Zondagh, I. M. Zondagh, R.

Hofmeyer, W. F. Howe, E. H. Marshall, R. Maxwell, L. S. Carter, A. S. T. Garland, F. H. Hayns, E. M. D. Mackie.

Mr. Lewin Payne.—Messrs. F. C. Gardenner, J. C. Faure, F. J. Fourie, M. Rubenstein, R. C. May, C. H. Archer, D. J. Baker, D. H. Batty, F. R. Payne, E. A. Sheppard, A. E. Tidd, W. H. Taylor, A. H. B. Heesom, A. L. Hodgkinson, E. A. J. Van Noorden, A. F. Porter, E. J. Joels, W. Rowland-Hill, F. A. Kerrison, B. Crisp, J. E. H. Duckworth.

Mr. Dowsett.—Messrs. G. M. Mew, A. Clarke, G. T. Hankey, R. S. Mathews, B. Rubinstein, F. A. Sampson, S. E. Sennitt, P. K. Albertijn, E. A. J. Bradley, T. C. Butler, H. A. Clarke, D. H. Overend, A. W. Reynolds, G. A. Sargent, E. G. Smallbone, G. F. C. Turle, J. H. R. Creasey, S. D. Neal, R. Edwards, A. Outram, F. G. Hutchinson, G. L. Shearar.

Assistant Surgeons' Dressers.

April—June, 1922.

Mr. Pearce.—Messrs. D. W. Griffith, T. G. Edwards, F. G. Davies, L. F. Handford, J. V. Bingay, W. L. Boness, F. Crone, H. M. Doubleday, C. H. A. Fido, O. P. James, H. Metheringham, A. D. Miller, J. R. A. Moore, V. R. Roberts, J. L. T. Urquhart, F. N. Van der Pant, E. S. Walmsley, A. R. H. Bennett.

Mr. Malleson.—Messrs. T. G. Lloyd, J. B. Maree, G. M. R. Van der Merwe, I. G. Coutts, A. S. Davies, E. E. Gibson, F. H. Goddard, E. V. Hayes, L. S. J. Kanaar, R. A. Tran, J. B. F. Tunstall, H. P. Baylis, C. E. Bowen, H. D. Hall, E. A. Lloyd, J. E. Lloyd, J. Luke, T. O'R. Clancy, A. S. V. Daniels.

Mr. Doubleday.—Messrs. R. Schlimmer, E. A. J. Ryan, S. A. Madgwick, W. Nicholls, F. F. Brayfield, P. S. Clarence, W. O. Cooksey, A. A. Danino, R. S. De Bruyn, A. H. Dyke, W. Orsmond, E. V. Potts, J. F. Reynolds, N. H. Saint, L. P. Tupling, T. Vallange, C. A. Wakeford, F. R. Taylor.

Mr. Pritchard.—Messrs. J. P. Hartman, C. L. Steyn, H. P. R. Williams, H. R. Allen, R. C. Ballard, T. S. L. Barritt, E. Eidinow, V. R. Estment, E. H. Fouraker, C. H. Fox, S. G. French, M. C. Hart, W. V. A. Hodges, C. D. Lingwood, M. W. Meskin, L. Nurick, A. Tuback, C. F. Shardlow, L. M. Cartwright.

Dressers in the Children's Department.

April—June, 1922.

Messrs. G. Wynne-Griffith, C. C. Brattle, L. Evans, J. B. Roberts, A. J. Britz, L. J. Godden, S. T. Hine, J. A. Hudson, R. C. Andrews, T. F. Fox, C. H. Stevens, R. H. Muller, M. Patlansky, E. Samuels, W. O. Sims, F. A. Walker, J. B. Hine, C. P. Urbani, S. R. Mutch.

Casualty Dressers.

April.—Messrs. G. T. Hankey, W. J. Williams, C. B. Wilson, T. G. Edwards, F. H. Hayns, H. Wayman.

May.—Messrs. G. T. Thompson, J. B. Maree, A. E. Tidd, R. S. Matthews, T. G. Lloyd, E. A. Lloyd.

June.—Messrs. T. C. Butler, R. Hofmeyer, R. Maxwell, E. A. J. Van Noorden, R. Schlimmer, E. H. Marshall.

Clinical Clerks.

April—June, 1922.

Mr. Doubleday.—Messrs. D. S. Hammond-Williams, W. E. Brigham, E. J. Clother, W. H. Foy, E. Z. C. Pearson, W. P. Beresford, W. S. Brittan, L. C. Willis, S. S. Sanderson.

Mr. Pritchard.—Messrs. H. B. M. Cahill, H. G. Brooks, W. Foster. R. M. Hastings, G. G. T. Tregarthen, V. C. Warr, O. J. Sidi, D. E. C. Robertson.

Notices.

BRITISH MEDICAL ASSOCIATION.

Scholarships and Grants in aid of Scientific Research.

SCHOLARSHIPS.

The Council of the British Medical Association is prepared to receive applications for Research Scholarships, as follows:—

1. An ERNEST HART MEMORIAL SCHOLARSHIP, of the value of £200 per annum, for the study of some subject in the department of State Medicine.
2. THREE RESEARCH SCHOLARSHIPS, each of the value of £150 per annum for Research into some subject relating to the causation, prevention or treatment of disease.

Each Scholarship is tenable for one year, commencing on October 1st, 1922. A Scholar may be re-appointed for not more than two additional terms.

The conditions of the award of Scholarships are stated in the Regulations, a copy of which will be supplied on application to the Medical Secretary of the Association, 429, Strand, London, W.C.2.

GRANTS.

The Council of the British Medical Association is also prepared to receive applications for Grants for the assistance of Research into the causation, treatment or prevention of disease. Preference will be given, other things being equal, to members of the medical profession and to applicants who propose as subjects of investigation problems directly related to practical medicine.

The conditions of the award of Grants are stated in the Regulations, a copy of which will be supplied on application to the Medical Secretary of the Association, 429, Strand, London, W.C.2.

Applications.

Applications for Scholarships and Grants for the year 1922—23 *must be made not later than Saturday, June 24th,* 1922, in the prescribed form, a copy of which will be supplied by the Medical Secretary on application.

Each application should be accompanied by testimonials, including a recommendation from the head of the laboratory, if any, in which the applicant proposes to work, setting out the fitness of the candidate to conduct such work, and the probable value of the work to be undertaken. This is not intended, however, to prevent applications for Grants in aid of work which need not be performed in a recognised laboratory.

ALFRED COX,
Medical Secretary.

429, Strand, London, W.C.2.
March 31st, 1922.

Annual Dance.

The Guy's Hospital Annual Dance will be held at Prince's on Friday, April 28th. Dancing 9—3. The tickets, which include buffet and supper, are 17s. 6d. each, and may be obtained from any member of the Committee:—Messrs. E. J. Crisp, W. D. Doherty, L. K. Watson, R. F. H. Duncan, G. D. Shaw; and C. E. Edney and D. J. P. O'Meara, Joint Secretaries.

Post-Graduate Courses.

A Post-Graduate Course of Clinical Lectures and Demonstrations will begin at the National Hospital for the Paralysed and Epileptic, Queen Square, Bloomsbury, W.C.1, on May 15th. The Course terminates on June 30th. It includes a large number of lectures and demonstrations by well-known neurological specialists. Full details will be found on the notice board in the Colonnade.

That Viva.

A Monologue in Spasms by a Thirty-second Year Man.

Sunday, 8.30 p.m.—Everything seems all right for next Tuesday morning. I think I know my work pretty well—really, I think I ought to pass easily.

Monday, 10 a.m.—I'll just look through the syllabus for the last time and make sure about it. There may be something I've missed.

10.15 a.m.—Great Scott! I don't know anything about anything! It's awful! What the devil am I to do?

10 p.m.—I'm feeling jolly tired. Suppose I'd better go to bed—nothing like a clear head for a viva.

Tuesday, 2 a.m.—I wish to goodness I could get to sleep!

8 a.m.—What a night! My stars and garters, what a night!

11 a.m.—Only another quarter of an hour to wait. Thank God I'll soon be out of this misery. Don't care what happens now. What? Won't be wanted till twelve? My sainted aunt, why the deuce do you put 11.15 on my card, then? Have I got to hang about here in this state for another hour? I'm going to become a Bolshevik.

12.15 p.m.—For the Lord's sake go away. No, I don't know what I was asked, and I don't care either. . . . No, I couldn't answer a dashed thing. . . . Goodbye. . . . Thank Heaven I'm out of that seething mob at last. . . . I can get time to think now. Let me see; he asked me . . . Holy Christmas, I don't *want* to think. . . . Double Scotch, please miss. . . . Ah, that's better. I'll have another like it, please.

11.45 p.m.—I'll have to go and get the result to-morrow morning. . . . Oh, curse the result!

Wednesday, 8 a.m.—In future I'll always be sorry for insomniacs.

11 a.m.—Hullo, coming to see the result? . . . Here we are. . . . Oh, blazes! I've failed. . . . No, I haven't! Here's the list. We passed, man, we've passed! Comeanavverdrink!

11 p.m.—It's quite all right, officer. Quite sober, you know. Just got my boots off to keep my head cool. . . . Why the deuce do you provide os—os—oscillating kerbstones when a man wants to sit down? . . . Oh, all right, then.

A week later.—Oh, yes, I got through all right. Vivas don't trouble me at all. Suppose I bluff the examiners somehow.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

When the "Gazette" was Young.

(*Continued*).

Highbury Barn.

In those early days there used to be a custom observed, which had apparently been handed down from "time immemorial." What the origin of it was I could never learn; what had given rise to it, or what it commemorated. It seemed to me to be one of those observances by which certain historical events were kept in mind, such as the stoning of larks on St. Stephen's Day, Plough Monday, and the Town and Gown at our Universities of November 5th. The custom of which I speak was kept, I think, on November 5th, but am not sure. I allude to the annual Highbury Barn Festival. I never took part in it, but clearly remember the conversations on the day after, in which the actors described their exploits, and counted their "spoils." Highbury Barn was a very popular dancing garden, to which people resorted after theatres. It was similar to Cremorne Gardens, but was less fashionable.

A Thing of the Past.

Each had its own special devotees, but I never remember hearing Highbury Barn referred to except on this special occasion; whereas nine out of ten people, on leaving, say, the Argyle Dancing Rooms, would give the word "Cremorne" to the hansom driver as their destination. Highbury was more a thing of the past, and its traditions, like the Bob Sawyer type of "medical student," was fast passing away. If the magic wand of memory were able to recall perfectly in every detail what there was to be seen when the Gazette first opened its eyes on the world, the Bob Sawyers would be but a small collection, growing rapidly much smaller and not in any way to be taken as representative either of a Guy's man, or even an ordinary "Medical student."

"The Day," and its Celebration.

It was by these men that the Highbury Barn tradition was kept up. At the proper hour, about 10 or 11 p.m., the group would enter the gardens, and partake of the dissipations which the place offered. One thing marked the hospital "set" and by it the members of the gang recognised each other, and that was that each one carried a short strong stick, about 18 in. or 2 ft. long and $\frac{3}{4}$ in. thick, made of oak or ash and capable of bearing a great strain. It was also an essential that they should wear garments having capacious pockets. For this reason the majority were dressed in what were known as "pilot jackets," a short blue jacket of thick, rough, blue cloth, such as were frequently worn by sailors. If they could not produce a coat with pockets, a temporary receptacle must be provided, for a large pocket or pockets was essential.

After the gaiety at "The Barn" was over and it was time to depart, our "short stick" fraternity would collect, for the most part more or less exhilarated, and deploy into the quiet streets in a body. It was arranged which particular area should be attacked, and on this they set to work. Houses in those days were, for the most part, not provided with door-bells, but nearly all had knockers. It was these knockers that were sought. The end of the stick was thrust through the hole or loop in the knocker and a sharp twist given, when the knocker would come off the door and remain on the stick. This was stored in the pocket and another attacked. In this way they proceeded until either their pockets were full or some other reason compelled them to desist. On the next day the bags were reckoned up and compared, and the particularly fine specimens were added to the owner's "collection." The more ornamental brass ones were appreciated most, also iron ones, if very large or old fashioned. Some had much larger bags than others, for I was told that there was room for much skill in giving the proper "twist" to the stick. A timid amateur would fail completely.

The Aftermath.

I heard very little, or nothing of this in after years; for as the metropolis spread northwards, Highbury Barn lost its attractions and was, not long after, I believe, used for building purposes. But in a previous generation Highbury Barn Day was a great institution, and many of its joys, and much of its wild excitement found an appropriate cooling room in a Northern Police Court. I think the day was November 5th, but am not sure; some older man might remember more accurately.

It will generally be found that there is a dull grey background to these wild scenes. Even if a man has a robust frame and an innate love of "sport," it is by far the most fun to let it explode and relieve its tension in College contests at cricket, football and other athletic exercises. For, as a rule, the Highbury Barn men were not athletes, and they were not prize winners. They were, practically all of them, men of little intellectual ability and no aptitude for work, but idle and slothful, with a strong tendency to dissipation and gambling as a means of filling up their time.

The Son of a Country G.P.

One tale is enough to illustrate my meaning, but I could give many. The one I have chosen is typical, and as I knew all the people concerned in it, it made a great impression on my work at the hospital, and was the means of my breaking away from a set with whom much of my early days of hospital life was spent. Much senior to me, was the son of a country practitioner, who died before he had saved enough to provide for his family. It was decided that the best way to spend this small amount was to keep on the practice by means of "locum tenentes" until such time as the son could get qualified, and himself take charge of the practice, and so keep up the home for his sister and mother.

This was backed up by all the friends of his father, and it would have been a useless effort for any new comer to have set up in the district. Everything was in favour of the success of the scheme. The son entered Guy's and all went well, until he forgot the conditions under which he was being trained. He forgot how his father had had to earn every shilling of the money he was spending. He forgot how very little there was even of that; how his mother and sister were living in the most economical way they could in order to send him his monthly dole. He forgot how, not only his own future, but that of his mother and sister, hung on this slender single thread. He neglected his work and spent the whole of his energies in having a "good time." He was a member of the Highbury Barn fraternity.

Nemesis.

He was kept in London as long as the money lasted, but by the time I entered Guy's he had left and was trying to carry on the practice without having acquired any qualification. Out of sympathy for others he was allowed to do so, and the "covering," though illegal was winked at. In the year the Gazette was born he broke his clavicle. I saw him then for the first time since his Guy's days. "Whatever were you thinking of? How did you fill up your time?" I asked. He laughed gaily as he replied, "Oh in colouring clays, and in going to the 'bra (Alhambra)." It was a terrible confession. For, with but moderate work and application, all might have been so different. This state of things even could not go on long, and the old home at last collapsed and its members were lost to view. I can count about six similar cases, but I can also recall others, country bred lads, who saw whither they were drifting, pulled up in time, set to and worked hard and achieved sometimes even brilliant results. These are hard dry facts.

A Coincidence in Names.

There was another incident, connected with the College examinations, which occurred about the same time as the Gazette was born, and which caused much amusement and occasion for each one to air his special genius for wit. It was the Primary Fellowship Exam. The candidates bore, for the most part, the names of animals or birds for their surnames. The number rejected was great, including all the animals, but only one of the birds. Mr. Howse was then a Demonstrator of Anatomy, and one of the best. After the results were published there was much sympathy expressed for the "bird" who was ploughed, as he was known in the dissecting room to be one of the best, and his success was looked on as almost certain. But he was a victim of that extraordinary mental condition known as "lost his head." As he came out of the room after the "written paper," I asked him how he had got on. He looked dazed and puzzled, like one coming round from "gas" or a slight anæsthetic, as he said, "I hardly know, but I begin to think not very well."

On going through the questions with him I was particularly struck with his answer to one of the questions relating to the relations of the last rib. It is, more or less, of a catch question, as some of the ligaments and other attachments are absent and others only rudimentary. The sorting out of these had evi-

dently been too much for him, for he included in his answers all the muscles attached to the lower border of the true and floating ribs, until at last he reached the xiphoid; he then finished off by including the rectus. "Never," I said, "surely you never put all this in your paper?" "I did," he replied, "I'm sure I did, but it don't seem to me right now. I don't know what made me do it."

This is literally true in every detail. He was a steady hard worker, and as we all knew from his answers in the dissecting room at "demonstrations," well up in his Ellis. I had before heard many accounts of Oxford and Cambridge men doing the same things in the 'Varsity examinations, but always looked on them as apocryphal until this experience.

I was present when Mr. Howse met one of the successful "birds" and heard him compliment him in his usual er—er style in these words: "I—er—congratulate—er—you, 'Mr. 'Dodo'—er—on your success,—er—but there are some—er—who say—er—that it would have been better—er—if the animals had passed and the birds—er—had been plucked—er—er. He, he, he!"

Timothy Holmes.

To recall "Timothy," whom I have mentioned before. How many are there now living who can say they have had him at a *viva?* I remember on one occasion he had for his co-examiner, the other one who was held in equal terror. It was at St. George's Hospital, for the Clinical part of the Final Fellowship. The cases in the ward chosen were all mixed up, contradictory, and unorthodox examples of injury and disease; at least those selected for our special cross examination. There were 12 candidates present, only two passed, the two Guy's men. Although I passed, I did not consider it was a fair test, being for the most part a wrangle on disputed points, between examiner and examined. I suppose it was their way, and therefore right, but quite unsettling to a man who was at all nervous.

Dr. Johnson of King's.

How different to Johnson of King's College, who in '73, was examining me at the College of Physicians. His question was, "How is it that the kidney can be injected from the aorta, after the renal artery has been tied?" I answered him truthfully and quite innocently from the pages of a book I had read, but of which I had forgotten the title. I began with these words, "I have read somewhere, I forget where, but I know it is on good authority, in fact *the best* authority that, etc., etc." The face of Sir George beamed with delight. "Ah!" he said, "I see you have been reading my lectures!" So I had, I remembered it instantly. I had no more questions from him but a long description of that, and other similar interesting cases he had met with.

Foreign Body in Bladder.

The words "interesting cases" reminds me of a man who came into Naaman Ward just about a year before the above event. He had a complicated history of vesical trouble, on which neither his history nor manual examination threw any definite light. The cystitis, etc., was severe and clearly showed that there was some objective irritation of the bladder. Nothing being able to relieve his symptoms, it was decided to perform a perineal incision as for lithotomy, and digitally explore the cavity. A bundle of something was easily removed, which entirely took away his pain. On being washed and examined, this bundle proved to be a bootlace, tied in a knot and bow and then the two bows again knotted loosely over the reef knot. "Why this is exactly how I tie the lace of my shooting boots," said Mr. Durham, eagerly, as he closely examined and untied the knot. "Exactly as I tie my shooting boots," he kept repeating. The bulk of the knot was about equal to the size of one's finger end. It was no irregular ravel, but a regular knot and bow, doubly tied. The question was, How did it get there?

The man's pelvis was thoroughly examined, but no recto-vesical lesion of any kind found. He was cross-examined in every possible way, but no history could be found likely to throw any light on the case. But even admitting that during a spell of debauch and intoxication, he had permitted one or more to put long pieces of bootlaces in his bladder, how had they done it. *We* could not by any means or instrument get even a small part of the knot into the orifice of the urethra or even into a No. 16 silver catheter.

It was admitted on all hands that it was physically impossible to place the knot in the bladder by any other means than by which it was taken out, that is by open incision, and

of this there was no evidence. It remained an unexplained mystery.

Foreign Body in Foot.

I was reminded of it some years afterwards when I was called in to see a boy's foot. It seems that some days previously, when fully dressed and wearing a pair of shoes, he was trying to move a chest of drawers. They fell and trapped his foot between the top edge and the boards. A doctor was called in who took off the shoe and sock and found a skin wound about 2½in. long, across the dorsum of the foot. This he washed and sewed up. The wound did not heal, but looked swollen and red.

At his request I saw it, and suggested taking out the stitches and exploring the wound. This was done. Inside the wound and completely hidden by the skin flaps was a piece of mohair bootlace about 4in. long. This was removed, the wound cleaned and all went well. But how did the long piece of bootlace get there? The doctor said he had never seen it. He took off the shoe and sock in the ordinary way, leaving, as he thought, the lace in the shoe, washed the wound and sewed it up, but saw no bootlace! How did it get there? The blow inflicting the wound would not occupy more than an instant of time. What opportunity was there for the accident to unthread the lace and force it through the sock and tuck it unseen into the inner cavity of the wound. It was incomprehensible, but nevertheless, there it was.

An Accident in Guy's.

Of the following case I was not an eye-witness, although I saw the man. I was, I know, holding some appointment at Guy's at the time, but he was not directly under my care, so that I forget the ward.

A man was occupying a bed in one of the surgical wards, waiting, I think, for the performance of some operation. The bed was a low one, just an ordinary ward bed as was in use at that time. He reached out his arm to get the utensil which lay under his bed. In doing so, he overbalanced himself and fell. His neck struck the edge of the pôt de chambre and broke it; the broken sharp edge of the pôt shore through the lateral muscles, ligaments, fascia, etc., with a clean cut like that made by a sharp knife and cut off, not fractured, the lateral process of one of the cervical vertebræ. This would excite no wonder if the result of the blow of an axe, but when it is taken into consideration that the distance giving the momentum was only a few inches, viz., the distance between the bed-frame, or mattress, and the top edge of the pôt, it was voted by all to be a unique occurrence, and the bone fragment was widely exhibited for some time.

(To be continued).

List of Books added to the Wills Library during the months of January, February and March, 1922.

F. A. Bainbridge.
The Physiology of Muscular Exercise, 1919.
Purchase.

Norman Black.
Local Anæsthesia in Dental Surgery.
Purchase.

Maurice Craig.
Nerve Exhaustion, 1922.
Purchase.

Arthur R. Cushny.
The Secretion of Urine, 1917.
Purchase.

George F. Gask and Harold W. Wilson.
Surgery, 1920.
Purchase.

The Works of John Hunter.
Edited by John Palmer, 4 vols., 1837.
Presented by Mr. Gibberd.

Arthur F. Hurst.
Medical Diseases of the War, 2nd edition, 1918.
Presented by the Author.

Robert Hutchinson.
Food and the Principles of Dietetics, 5th edition, 1922.
Purchase.

T. B. Johnston.
Regional Anatomy.
Purchase.

Keen's Surgery.
Volumes 7 and 8. Supplementary, 1921.
Purchase, Davies-Colley Fund.

Claude B. Ker.
A Manual of Fevers, 1921.
Purchase.

Hugh McLean.
Modern Methods in the Diagnosis and Treatment of Renal Disease.
Purchase.

Medical Directory, 1922.
Purchase.

J. B. Parfitt.
Operative Dental Surgery.
Purchase.

James Sherren.
Lectures on the Surgery of the Stomach and Duodenum, 1921.
Purchase.

Syllabus of Lectures on Midwifery delivered at Guy's Hospital, 1799.
Presented by Dr. Eason.

Alexis Thomson and Alexander Miles.
Manual of Surgery, 3 vols., 6th edition, 1922.
Purchase.

Percy Wilde.
The Physiology of Gout, Rheumatism, and Arthritis, 1921.
Presented by Dr. French.

Sir Kingsley Wood.
Dental Registration, 1921.
Presented by Mr. Nicolai.

Football.

RUGBY.

GUY'S v. SWANSEA.

There was heavy rain in Swansea for this match on March 25th, and consequently the crowd was not so large as expected. Van Niekerk was early called upon to save, and this he did exceedingly well, his tackling and general defence being very sound. The forwards, however, led by Doherty and ably backed up by the same men as played at Portsmouth, got the ball to midfield. Further good play by the forwards followed, and Neser gained a resulting try to which Harvey could not add the extra points. Steyn next came to the fore in defence, and then the Hospital back division handled in first-rate style for Mostert to get within a very short distance of the line. Shortly after this, Albertijn rescued us from a trying position. Van Niekerk's kick being charged down, and the ball rebounding, Harding got it over the goal line, but Albertijn touched down.

The second half opened with the Swansea pack, who, by the way, were not at full strength, going great guns. The home three-quarters were not so prominent, and all their attempts at passing and running were successfully dealt with by Guy's defence, Sprong being the most prominent. Both Taylor and Watson lent valuable aid in this department. Steyn might have run round Rees, the full back, one thought, but he kicked instead, and it should be said that the kick was exceedingly well judged and ill luck alone was responsible for no resulting score. Steyn had another good run just after, but as time wore on the home team made desperate efforts to score. Then with only a few seconds, almost, to go, a free kick was given against us in such a position that a penalty goal could scarcely fail to accrue. It was very hard lines indeed that having led this famous Welsh team all through a hard game, the last minute should, in such a fashion, rob us of what appeared a certain victory. Score—Guy's, 1 try (3 points); Swansea, 1 penalty (3 points).

Guy's Team.—A. K. Van Niekerk, C. L. Steyn, J. G. Van Schalkwijk, P. G. Albertijn, G. Mostert, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, E. H. Fouraker, W. H. Taylor, L. K. Watson, E. E. Neser, P. G. Harvey, G. Zondagh.

GUY'S v. NORTHAMPTON.

The same team as did duty at Swansea, with one exception, went to Northampton on Saturday, April 1st, and managed to inflict a defeat on the local team by 3 tries or 9 points to nil. It is an agreed fact that Northampton were fortunate to escape so lightly, for many opportunities of scoring came our way, and truth to tell, very few were used to advantage. Sometime before half the game was over Northampton lost a forward, in the person of J. B. Merry, who broke a collarbone, but it was not so much among the forwards that disparity was noticeable. In this department Northampton were excellent, but behind the pack the Hospital were tremendously superior. That we did not score more was due entirely to lack of going for the line. We only got one try before the interval, and that a somewhat lucky one. The ball was punted over the full back's head and Sprong touched the ball down before J. I. T. Jones could do so.

After half-time a very fine try indeed came from P. K. Albertijn who got clean through the opposing side in the most extraordinary fashion. Neser was unsuccessful with the place. We had one or two attacks to resist, but the passing that led up to them was rather apparent, and fortunately our defence could easily concentrate in time. The forwards, not quite so aggressive in the loose as usual, provided, from the scrums, plenty of chances for the open game. Bekker was good, and Sprong has seldom done better. Many and good were the bouts of passing, but the final thrust was lacking and a successful ending did not accrue until Mostert suc-

ceeded in crossing the line in the last few minutes of the game.

Final score:—Guy's 3 tries (9 points), Northampton nil.

Guy's Team.—A. K. Van Niekerk, C. L. Steyn, P. K. Albertijn, J. G. Van Schalkwijk, G. Mostert, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, W. H. Taylor, E. H. Fouraker, L. K. Watson, P. G. Harvey, G. Zondagh, F. J. Biddle.

Reviews.

Experimental Physiology. Sir E. S. Schafer, F.R.S. (Messrs. Longmans, Green & Co.) 6s. net.

The third edition of this book contains a record of all the essential experiments which a student performs during a practical course of Experimental Physiology. It gives a clear and reasoned account of the experiments to be completed, while the diagrams of apparatus and of its connections are both numerous and clear. At the same time, a few diagrams as to the results obtained would form a useful addition in such experiments as those on Electrotomes, with an amplification of the mode of dissection of the vagus in the frog, at the expense of such experiments as excitation of the cortex cerebri in the monkey which the average student never has even demonstrated to him.

Obituary.

PEDLEY.—On January 13th, 1922, at Bridge House, Rangoon, suddenly, of heart failure, Thomas Franklin Pedley, M.D., V.D., K.I.H., eldest son of the late George Pedley, of The Haven, Sutton, Surrey, aged 67. (By cable). R.I.P.

At the close of the Rev. J. A. Drysdale's sermon at the Scots Kirk, Rangoon, on Sunday evening, the 15th January, 1922, he said as follows:—

"Very suddenly on Friday evening we lost from the Company of the Church Militant a dear friend, neighbour, and fellow-worshipper—Thomas Franklin Pedley. I do not trust myself at this time to speak many words of one who honoured me with his friendship and to whom I owe many and great kindnesses. But I am only one of many who desire to pay to his memory a tribute of affection and of esteem. Born sixty-seven years ago last Christmas Eve, Dr. Pedley gave forty-two years of a vigorous, active, many-sided Christian life to this city of Rangoon and to this land of Burma which he loved. We need not praise him. His own life, his deeds, his memory are eloquent with high service and generous purpose.

When last evening the great company of all ranks and classes of the community came to lay to rest in the Cantonment Cemetery what was mortal of him, we all knew we had lost one whose place will not be filled in our lives and hearts.

There is given to the great profession of which Dr. Pedley was an honoured member—more perhaps than to any other—certainly in a wider and more general way—a key to the hearts of men. That is the key of close personal interest and of sympathy, of help, of friendship. This key to many hearts Dr. Pedley had. It is an encouragement to us to remember, at a time when so many of our Burmese and Indian fellow-subjects disbelieve in our concern for them and their welfare, we had one of our number in whom all those who met him and knew him could not disbelieve. He was a Christian gentleman who, because of his own Christian faith, was enabled to maintain these long years—and more especially these later years shadowed by death and the absence of his loved ones—a deep and patient sympathy with the afflicted of all races and creeds. It is not possible to believe that this full, active, kindly life is at an end, any more than to believe a great river ceases to flow when it passes over a fall in its course. We give thanks to the Awful Disposer of Life and Death for this gift to us of a strong, brave triumphant life; and we surrender back to Him what He lent to us for a season.

We mourn one who was dear to us. We give our sympathy to his bereaved daughter and sons, to his family, and to the wide circle of his friends. We ask for them the consolation of God.

We have no need to sorrow as those who have no hope.

'Come away: for life and thought
Here no longer dwell
But in a city glorious,
A great and distant city and have bought
A mansion incorruptible.
Would they could have stayed with us.'
Amen."

The whole of this was delivered by the Padre with deep emotion which his voice betrayed.

The service closed with the beautiful hymn beginning: "How bright those glorious spirits shine."

Publications Received.

British Medical Journal, The Serpent (Manchester). St. Bartholomew's Hospital Journal, St. Mary's Hospital Gazette, The Prescriber, The Antiseptic (India), The Nursing Times, The Manchester University Medical School Gazette, London Hospital Gazette, The Epsomian, Indian Medical Record.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

VOL. XXXVI., No. 882.] APRIL 29, 1922. [NINEPENCE.

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Passim.

THE most cursory glance at our correspondence columns could hardly fail to reveal an attitude of distinct disapproval of our recent criticism of the pamphlet issued by the Labour Party, expressing their views on hospital administration. And it must be admitted that we have laid ourselves open to criticism—not, as Mr. Weinbren suggests, by the exhibition of a biassed state of mind, but rather by attempting, in the limited space at our disposal, to present any review whatsoever of so comprehensive a document as that under discussion. Let us make it clear that we do not regard the writer of this pamphlet as being in any way "underhand," in his method of dealing with the situation. We described the report as an attempt to disseminate propaganda, and this it undoubtedly is. It may, we think, be justifiably regarded as a plank in the political platform of the Labour Party. As Mr. Rogers points out in his letter, it is an appeal to the electors of the country, setting forth the lines on which hospitals would be run were a Labour Government in power. It is to be welcomed as an honest expression of opinion upon a difficult question, but there is no necessity to agree with it. We are not primarily concerned with the ethics of publicity. Our object is to point out what we consider to be fallacious in the views to which publicity has been given, and it was from this point of view that we approached the subject in our issue of April 15th. Apparently our correspondents would prefer us to laud the Labour Party to the skies for being such honest fellows as to say what they think!

Mr. Rogers has dealt at some length with the points which we raised in connection with the paragraph on "Anomalies of the Voluntary System." Our experience has in many respects differed from his. For instance, we meet numbers of nurses daily who, though working hard at their particular tasks, yet do manage to convey a very real impression of individual sympathy to the patients under their charge, and this in spite of a "general brisk cheerfulness." We suggest sympathy is a question of individual character, not of the effects of a system, and that even with little to do some people could be most unsympathetic towards patients, while others, perhaps more busily employed, could endear themselves to all by their kindly attitude.

In criticising such a report, however, there is a danger (only too obvious in the present discussion) of wandering from the real issue and devoting one's attention exclusively to quite minor details.

The opinion which we most of all desire to oppose is that which holds that so highly specialised a profession as ours can be adequately administered by any Government—be it Labour or anything else. We consider that were the recommendations of the Labour Party's report carried out, the whole medical profession would tend to become in time a sort of Government Service, with the inevitable result that methods would become cut-and-dried and unintelligent.

The nation's health is its most important asset, and the recognition of this fact does the Labour Party credit. But the methods by which it seeks to attain the ideal strike us as being not only financially unsound, but also calculated to impair rather than enhance that sympathy which should exist between doctor and patient.

We have been asked to request any old Guy's man who has votes for admission to Epsom College to give them to Denis Astley Sanford. The late Dr. Sanford, a Guy's man, died in 1918, at the age of 33, after five years' illness, leaving his widow and son in straitened circumstances. There is appended to the appeal, which we publish on page 183, a list of those who recommend the case. Their recommendation should be sufficient evidence that it deserves support, and we trust that all Guy's men with votes or influence will use them to help Mrs. Sanford.

Why will people persist in removing periodicals from their covers in the College Reading Room? The obvious reason for the provision of these covers is the protection of the various journals, and it seems unnecessary to remove one from its cover before reading it.

It has been suggested that a single cover be provided for the various journals which are received from other Hospitals and Universities. The provision of several strings down the centre of the cover would permit of several papers being placed within the same cover, and it might be a good scheme to have these journals kept together, instead of scattered about, as at present.

Our only objection to the suggestion is that they would inevitably be removed from any cover provided, and scattered about again!

The practice of sending a copy of standing orders for the duties he is about to undertake, to every student entering on a new appointment, has now been definitely re-established. Any student, therefore, who has not as yet received a copy of the orders for his new appointment is advised to obtain one from the Medical School Office.

Medical and Surgical Ward Clerks who have not procured a copy of the instructions for case-taking, which may also be obtained from the Medical School Office, should do so. The issue of these little books was suspended for some time during and after the war, and they are now given out in a revised form. They contain much information likely to be of use, even to a ward clerk who is convinced he knows all about it. No one should be without them.

The attention of men in the wards is directed to the notice, on page 183, of the summer course in Insanity. Those whose Final examinations are gradually becoming an unpleasant reality, rather than a vague possibility, and who have not been "signed-up" for a course of lectures and demonstrations on Insanity, will be well advised to take advantage of this oppor-

tunity of doing the course. In addition to the advantages of lectures by Sir Maurice Craig and demonstrations at Bethlem, it is well to remember that no fee is charged for this course.

THE Guy's Hospital Ladies' Association propose to hold a Garden Fête in the Hospital Grounds on Thursday, June 29th. As will be seen from the notice which we publish in this issue, a most attractive programme has been arranged. In addition to the usual features of such functions—stalls for the sale of all sorts of articles (including gramophone records), tea, ices, and a band—there will be dancing in the Nurses' Home.

The activities of the Ladies' Association have, in the past, produced excellent results. (It will be remembered that last year they subscribed, and collected in various ways, the sum of £1,125, which was devoted to the support of eight beds in the Maternity Ward, and six cots in the Children's Ward.)

We trust that all Guy's men and women who can do so will support the Fête by being present. In so doing they will make it not only a financial, but also a social success.

WE are very glad to hear that Dr. Arthur Percy Allan has been presented with the Diploma and Insignia of the Médaille du Roi Albert, for services to wounded Belgians during the War.

Events of Interest for Fortnight ending May 13.

May 1.—5 p.m., *Prof. Shattock: Specimens Illustrating Sarcoma.
5.30 p.m., Johan Hjort, Ph.D. on "Biological Aspects of Oceanography: Distribution of Species in relation to their external conditions," at King's College, Strand.

May 2.—5 p.m., Sir Arthur Shipley on "Lice: Their habits and life history, and their relation to disease,' at University College.
5.15 p.m., †"Instinct and Emotion."
5.30 p.m., Johan Hjort, Ph.D., on "The valuation of the Sea," at King's College.

May 3.—1.30 p.m., Clinical Lecture by Dr. Hunt on "Precordial Pain," in the Anatomical Theatre.
5 p.m., Prof. C. Winkler (University of Utrecht) on "The Human Neo-Cerebellum," at the Royal Society of Medicine, Wimpole Street.

May 4.—4.30 p.m., Clinical Lecture by Mr. Layton on "Local Anæsthesia in Nose, Throat and Ear Work," in the Anatomical Theatre.
8.30 p.m., Beggars' Dance, Gala Night at Knightsbridge Hotel.

May 5.—5 p.m., *Prof. Sir A. Keith: Umbilical and Diaphragmatic Hernia.
5.15 p.m., †"Dissociation."
5.30 p.m., Johan Hjort, Ph.D. on "The Growth of Fish in the Sea," at King's College.

May 8.—10 a.m., Examination for Beaney Prize for Pathology.
Clinical Lecture by Mr. Ormond.
5 p.m., *Prof. Shattock: Specimens illustrating Tuberculosis.

May 9.—5 p.m., Sir Arthur Shipley on "Bed Bugs and Ticks as Conveyers of Disease," at University College.
5.15 p.m., †"The Unconscious."

May 10.—Clinical Lecture by Mr. Turner.
5 p.m., Hunterian Lecture at College of Surgeons by Prof. H. Burrows on "The Results and Treatment of Gunshot Wounds of the Blood Vessels."

May 11.—5 p.m., Second Hunterian Lecture by Prof. H. Burrows on "The Results and and Treatment of Gunshot Wounds of the Blood Vessels."
5.30 p.m., Advanced Lecture in Botany at Birkbeck College. Prof. Dr. J. C. Schante on "Whorled Phyllotaxis."

May 12.—5 p.m., Advanced Lecture in Anthropology, at the London School of Economics. Dr. Peter Giles on "Modern Views of Indo-European Origins."

May 12.—5.15 p.m., †"Suggestion."

*Museum Demonstrations at the Royal College of Surgeons.

†A course of lectures on "Psycho-Neurosis," at the London Hospital (Clinical Theatre) by Dr. Millais Culpin. Fee for the course, One Guinea.

Publications Received.

British Medical Journal, Nursing Times, The Hospital Gazette, St. George's Hospital Gazette, University College Hospital Magazine, Architectural Association Journal, The Dragon (Aberystwyth), The Old Cambridge, The New Cambridge, The Burma Medical Times, New Zealand Journal of Health and Hospitals, L'Informateur des Aliénistes et des Neurologistes, L'Encéphale.

Pyorrhœa Alveolaris.

Read before the Dental Society by Mr. H. SLATER.

If we look up pyorrhœa alveolaris in any text book, we find synonymous with it, chronic general periodontitis commencing at the gingival margin, Rigg's disease, alveolar osteitis, periodontal disease, interstitial gingivitis. We don't know its pathology, therefore we don't know what to call it—moreover we don't know how to treat it—there is a different treatment for each name, and a fresh one comes out every fortnight in the *B.M.J.*

However, there seem to be a few generalisations we can make to begin with. First, we generally find pyorrhœa in adult life and in the middle of it—anything from 35 to 55—we can verify this by our own observations in the Conservation Room. Second, people possessing the strongest, whitest, and most highly calcified teeth generally seem to be the greatest sufferers. Further, dead teeth usually seem to be immune—this may be accounted for on the theory that the circulation which should normally pass to the pulp is diverted to the periodontal membrane and surrounding structures, thus raising the local resistance and offering a more efficient local protection against bacterial infection.

A definite single cause of pyorrhœa has yet to be found, but there are a number of possible causes of which we can be tolerably certain, and these are divided into predisposing and exciting or immediate. Constitutional predisposition in some way or other seems to be at the bottom of it—there may be immediate causes which might affect one or a few teeth, but the majority of patients have the greater portion of their mouth affected, and there must obviously be some constitutional failing to allow one person to become a sufferer from it, while his immediate neighbour, living under the same conditions, is free. Whether heredity is the cause of this predisposition or not, however, seems to be a matter of personal opinion to some small extent, but all the evidence seems to be against it. At any rate that a number of wasting diseases may cause it there is no doubt, not through direct infection, but nutritional and metabolic disturbances—such diseases as diabetes, malaria, gout, rheumatism, and alcoholism, and it seems probable that a number of chronic diseases produce toxins which have an affinity for the alveolus and gingival margins. We have often been shown in the Conservation Room, a blue pencil mark along the line of the gums. I don't mean to suggest that this be any evidence of pyorrhœa, but if a poisoning such as lead should show itself just there and affect that part only, it seems possible that there is some constitutional inherent weakness of that gingival tissue, and it has been suggested that toxins of certain chronic diseases may affect that part of the mucous membrane more than any other. Bad housing and general living conditions do not seem to have very much effect on the causation of the disease, but modern soft pappy food undoubtedly does—especially vitamines. The absence of the antiscorbutic Food Factor is found to be a strong predisposing cause. Constipation, the most important factor of all, I will mention later.

There are some cases in which no immediate cause can be traced, but in the majority of patients there are a large number of conditions locally, any one of which may be enough to start the disease. Abnormally hard biting on one or two teeth—the forcing of fibrous food down between the teeth or on the gingival border—food fermenting in the gingival trough—salivary calculus or tartar—bad conservative work improperly contoured or causing a food trap, the use of a clamp too high up and injuring the tissues, irregular dentition, or mouth breathing. These are some of the local conditions which have been put down as immediate causes. But whatever it is, it begins by lowering the local resistance or causing an actual breach of surface in the epithelium or injury to the periodontal membrane in some way or other, through which bacterial infection may occur.

Whatever is the cause of the primary lesion, the second stage is that of bacterial infection, and inflammation of the gum tissue or gingivitis follows, with inflammation of the periodontal membrane. This then involves the small point of bone, which becomes absorbed. A small pocket is thus formed which, unless treated, gets larger, and so gradually passes on to the advanced stages—sometimes more quickly than others—ferments have removed the periodontal membrane from the cementum—the pocket formed is a stagnation area and septic focus, and grows bigger and bigger, generally extending further between the teeth than on the labial or lingual sides. Pus is nearly always present in the later stages, whether it is there at the beginning or not. The rapidity of destruction depends on the virulence of the infecting organisms and on the local resistance of the tissues. This process will continue with or without complications until the tooth has no more attachment to its socket and falls out, when the whole condition automatically clears up.

Patients may come to us presenting a number of clinical appearances, and we can divide them into two classes, according to whether they show general symptoms from the disease or not. Those who do not, give every prospect of success in any treatment, for their general resistance is good. The other class may be found to suffer from any number of ailments or maladies, any one of which, or all,

may be put down to pyorrhœa—general malaise, rheumatism, headaches, anæmia, rheumatoid arthritis particularly, and almost anything including housemaid's knee. It is surprising how many disorders are put down nowadays to dental sepsis, and a lot of trouble is caused through the general painlessness of the disease, especially in its early stages. The danger of it may be gauged when we realise that a patient may go about with a highly septic mouth for years and know nothing at all about it.

If a direct microscopical examination of a swab from a pyorrhœa pocket be made, all the usual mouth organisms will be found, which are present in everybody's mouth. In addition pyogenic, or pus-forming organisms—and the following varieties: first, *spirochætes*, large and smaller, and *fusiform bacillus*—not to be mixed up with bacillus fusiformis. These two varieties of organisms are always to be found in cases of pyorrhœa—where pyorrhœa is, there they are. Preparations of arsenic are particularly deadly to these varieties, so Liquor Arsenicalis is a useful drug for local application. In addition to these spirochætes and fusiform bacillus, leptothrix is found—this organism is the basis of all tartar—the leptothrix are on the surface of the root all the way down and calcium salts are deposited on them as tartar. On the roots it is generally greenish in colour and called semminal tartar, from being deposited from the blood serum. The large masses of grey or white found round the necks of teeth, particularly lower incisors and upper molars, are enormous masses of calcium salts deposited on the leptothrix from the saliva.

The organisms mentioned so far are those found in direct examination of the pus from a pocket. If a swab be taken from a pocket or from the region of the extracted root near the apex, and *cultivated*, on agar, blood agar, or glucose broth, the most important organisms of all can be recognised. These are streptococci—in three varieties—streptococcus longus, streptococcus hæmolyticus, and streptococcus viridans. The latter is the one often associated with rheumatoid and other varieties of arthritis. The advantage of cultivating on glucose broth is that it inhibits all the other organisms, and allows only the streptococcus to grow. These streptococci are the most important organisms concerned with the disease and we have a very efficient means of combating them in electrical treatment. It has been proved bacteriologically by taking swabs and cultivating them, that two sittings of ionisation applied to a pocket for twenty minutes at a time, are sufficient to kill these organisms, and completely sterilise the pocket. The pocket may become reinfected, but that is all that is necessary to sterilise them.

The basis of ionic medication is this: any salt in true solution is split up into positive ions or anions and negative or kathions. When a current passes through a solution, the kathions travel to the positive pole, and the positive ions to the negative pole. The tissues of the body are conductors and contain salts which will conduct a current. If some cotton wool be placed on the gum soaked in a salt solution, and a direct current passed through this to the gum and then through the body to the other pole of the battery, metallic ions are set free and penetrate the tissues, and it is found that these ions exercise a strongly antiseptic and healing effect. In an experiment by Sturridge, using an electrode wrapped with cotton wool moistened in ferrous sulphate, connected to the positive pole and pressed on to a dog's gum for three minutes with a current of 5 m.a., it was found by staining afterwards with Pot. Ferrocy. that the Prussian blue stain, indicating iron, extended right through the gum to the epithelium on the outer surface, and for 12 mm. into the bony structure of the jaw. Antiseptics applied to the surface of the gum have only a superficial effect, and have no influence on those micro-organisms which are deeply seated. This ionisation, however, penetrates the tissues in all directions to a considerable depth, and not only destroys the bacteria, but also stimulates the tissues so that they themselves have a greater resistance.

We now pass to a most important realisation—which is, that pyorrhœa is invariably associated with intestinal stasis or constipation—the patient may not know it, but stasis of some form is always present, and a usual condition is that the patient is a sufferer from chronic constipation. The importance of this is realised when we discover that the three forms of streptococcus are found in the fæces, and can be cultivated in exactly the same way as specimens from the apex and the pocket. The connection between the two is obvious, and we may further state, as a general axiom applicable in all cases, that where there is no stasis, there is no pyorrhœa.

The first obvious course of treatment for pyorrhœa is therefore to get rid of what may be the cause of the whole disease—treat the stasis and keep the bowels open and regular. The most useful drug for the purpose is Paraffin. It acts chiefly as a lubricant in the intestine. The patient should also take Agar. The most usual cause of constipation is that the food is too little in bulk and the wall of the intestine has nothing to grip on, so to speak—the stimulus to peristalsis is distension of the intestine, and if there is nothing large enough in bulk to distend it, stasis will occur. Agar is not absorbed, and provides the necessary bulk.

A vaccine for pyorrhœa is generally cultivated from the streptococci—together with micrococcus catarrhalis—which is also found in the pockets and apex and seems in actual practice to make the vaccine more efficient. The vaccine itself is pre-

pared from the streptococci in the fæces, though where it is prepared from doesn't really matter. So many million dead bacteria are injected subcutaneously to be absorbed into the circulation, and produce antitoxins in the blood which are antagonistic to those special bacteria, and so attack any site of infection and raise the general resistance against them. It is useless to give vaccines only for treatment—they may improve the general condition, but cannot be expected to cure the disease. The use of vaccines is as a help in the general treatment of the disease. In the same way it is useless just to scale, or to treat the condition only locally—the pyorrhœa is a symptom of a general disease and cannot be expected to clear up unless both local and general treatments are undertaken together.

For local treatment, the first thing is an examination of the mouth—any teeth which have pockets extending more than about two-thirds the way down the root, that is to say, where the bone is absorbed for that distance, should be extracted, before any other treatment is attempted. The looseness of the teeth doesn't matter very much—if there is sufficient bone there, under efficient treatment they will become firm again, and a tooth has to be very loose to be functionless—a number of patients came up to the Hospital for treatment and present teeth which have just an *attachment* to bone at the apex, which prevents them from dropping out, and are held in an upright position by the gum on each side. However treated, it will be impossible to save these. Therefore, remove them and their harmful effects as soon as possible.

After extractions comes scaling—not removing the huge chunks of tartar from around the necks of the lower incisors and upper molars only—remember the leptothrix are all the way up the root, therefore the whole extent of the root in the pockets has to be scaled. This operation is, by its very nature, a lengthy one, and tiring both for the surgeon and patient, but is absolutely necessary. The best way to do it is to begin with one tooth and finish it, then go on to the next. To do it properly the most useful instruments are Abbott's scalers as they are called (flat ones) with the end turned back and sharpened. With these the bottom of the pockets can be reached without doing any damage to the tissues and the tartar removed all the way up the root. Younger's scalers—something like long and narrow gold files—are very useful for polishing the root afterwards. Unfortunately the instruments supplied with our cabinets are not enough to allow the scaling to be done most quickly and easily, but with the proper use of those we do possess a considerable improvement could be made upon the methods usually employed upstairs in the Conservation Room.

With the teeth mechanically clean, we can begin to use drugs for local application—you remember we mentioned Liquor Arsenicalis previously, as being particularly good in getting rid of the Spirochætes and fusiform bacillus. In addition, Chromic Acid 5 per cent. is very useful—better than iodine—and if one wants a liquid to use when scaling, chromic acid is indicated. If the scalers are dipped in this every now and then, it may not do very much good, but will prevent them from doing any harm. 1 per cent Silver Nitrate is also very good locally. When any of these drugs are to be put on the gum, the mucus there should first be removed with normal saline.

When we have rendered the surrounding tissues as healthy as possible, we come to the treatment of the pockets. We have here, a tooth on the one hand and gum tissue on the other, and in between the two there is a space—a space which, at any rate in lower teeth, has no natural drainage—it forms a constant food trap and septic focus, and if anything does happen to get down there, nothing in the natural course of events will remove it. If pus is there, squeezing and massage of the gums will remove part of it, but not all. A treatment may be undertaken of having the patient up at frequent intervals for the rest of his life and repeatedly scaling him and washing out the pockets, but it doesn't get to the root of the trouble. The whole point is, the pockets must be removed and the gum made self cleansing. How is this to be done? There are three ways—First, by removing the tooth; secondly, by causing the gum tissue to adhere to the tooth again and so obliterate any space; and thirdly, by removing the flap of gum, and so the outer wall of the pocket.

Removal of the tooth is done in acute cases only; we cannot lay too much stress on the importance of keeping the teeth, if it can be done with no ill effect to the patient. Of course, in our zeal for his welfare we must not forget that patients have opinions of their own, unfortunately sometimes, and may have a rooted objection to our proposal, or be unable to pay for the more elaborate and lengthy treatment which would give him the best results—in which case extraction is undoubtedly the only alternative. But if the patient is willing and the tooth can be restored to an aseptic and functional condition, keep it—it is infinitely more useful than any substitute that was ever made. Wholesale removal and refurnishing agents are not so bad as wholesale retention merchants, but most of them seem to spend too little time and trouble trying to save affected teeth when a *cure* is quite possible with radical treatment—and by a cure we mean a reduction of the seat of the disease in the mouth to a permanent normally aseptic condition. We cannot prevent the invasion of the ordinary

mouth bacteria, but we can prevent any further inflammatory or destructive and absorptive process, and we can make it self cleansing so that repeated lengthy treatment at the hands of the dental surgeon is unnecessary, and the patient will not be a sufferer in any way from the teeth.

Some people claim that by certain processes and treatments they can make the gum or periodontal membrane adhere to the root again, but their evidence seems very inconclusive and the general success of their treatment improbable—so we are left with the third alternative—to remove the flap of gum forming the outer wall of the pocket.

The best plan to achieve this end is to try first of all astringents on the gum. Sometimes these cause it to shrink and form a tight healthy gum retracted from the crown and closed round the base of the pocket. If the gum can be persuaded to recede and obliterate the pocket in this way, any further treatment is unnecessary, but very often this does not happen, so the gum has to be removed by operation—this may be done either by excision or the cautery.

Let us then consider the operation "gingivectomy," as this is called. A superficial local injection of novocain and adrenalin is given, to provide sufficient complete anæsthesia for the gum and to prevent excessive bleeding. The extent of the pockets is defined with a blunt instrument—don't always keep on pushing probes down pockets and lacerating the tissues—and all the gum removed, with a scalpel of some sort, as far down as the base of the pocket—first on the inside, as this is the more difficult position, then on the outside, and each should be carried as far between the teeth as possible. Not only should the strip of gum be removed from the buccal and lingual surfaces, but essentially in between as well. The whole operation should be done so that all the gum is removed, so as to leave no pocket at all. As a considerable raw surface is thus exposed for the direct absorption of toxins, the gum flap should not be removed from too many teeth at once, three or four in an average case would be enough, and in severe or advanced cases not so many. The patient may afterwards run up a temperature and become generally debilitated, as a result of this absorption of toxins, so too much should not be attempted at one sitting. It is a good thing after the operation to put trichloracetic acid on the exposed surface so as to virilate the tissues with the formation of new gum, which is really scar tissue, which grows up just a little above the level of the incision, and closes tightly round the root of the tooth. It must be borne in mind that this is a surgical operation and must be treated as such—care must be taken to sterilise the tissues round the field of operation before beginning—hands and instruments must of course be clean and the latter sharp. The cleaner the cut, the less painful afterwards to the patient, and the more chance there is of a clean healthy wound; moreover, it makes it an easier operation from our point of view. Special instruments are generally necessary. Instead of using the knife for the operation, the electric cautery may be used—it is particularly useful for places inaccessible to the knife, such as the distal surfaces of posterior teeth which are standing by themselves, and in between the teeth, and indeed may be used for the whole operation if found more convenient, as it leaves no raw surface for the absorption of toxins.

It is advisable to wait some little time until the first part of the gum treated is healed before continuing the operation to the teeth left.

What we have left when the operation is finished and healing complete is the teeth in the same position as before, but with the gum considerably receded and closed round the roots of the teeth as far down as the pockets extended. This naturally exposes a certain amount of cementum, which may be sensitive. If it is, it should be cauterised with Silver Nitrate or Zinc Chloride in the ordinary way. If the teeth were a bit loose before, they will be found to tighten again, and this treatment is particularly useful in cases where only the lower incisors and canines are left standing; and they are too loose in their present condition for the insertion of dentures. After operation they will be found quite tight enough to hold anything in position.

All surgical operations are painful afterwards, and this is no exception to the rule—sometimes it is acutely so, but the pain passes off normally as healing proceeds.

If the upper incisors have been operated on and the patient shows a good deal of the gum when smiling or talking, the result may look unsightly if much of the root is exposed—such a case must be investigated previously, and the patient told exactly what will happen and what a cure will necessitate. This is one of the disadvantages of the operation which will weigh most with the average patient, but no objection can be raised to the treatment of posterior teeth as a rule, and front ones the roots of which do not show after the operation. It is the obvious treatment of the disease and is widely practised both in England and abroad—a large number of surgeons practise it as a routine operation, especially in cases where there are only one or two teeth affected, and I have not heard anyone, who has performed the operation, condemn it.

If a patient comes to us, therefore, suffering from pyorrhœa alveolaris, the first thing to be done is

to enquire into the general symptoms—find out if there are any constitutional ailments such as rheumatoid arthritis, which may be due to it—try and and obtain a history of intestinal stasis—and then examine the mouth. If there are any teeth which, in your opinion, would be functionless if treated and cured, remove them. Extract them as soon as possible—the sooner the better—though it is advisable to make the mouth fairly clean first by syringing and any other local treatment one may have a fancy for, so as to avoid any unnecessary absorption of toxins from the sockets after extraction. Then begin straight away with the general treatment:—prescribe first for the constipation, and treat with intestinal antiseptics.

Take specimens for a vaccine. This is done in the following way, according to Dr. Eyre:—

"The patient is instructed to grasp the lip opposite the affected teeth with the forefinger and thumb of each hand and draw it away from the gums; in some cases a small roll of absorbent cotton wool is packed into the sulcus between the alveolar process and the lip. The gum margin is next wiped with a sterile swab of cotton wool mounted on the end of a stick, and the gum itself dried with a second sterile swab. Then with another swab firm pressure is made on the gum over the root of the tooth. The first drop or two of pus that exudes is mopped up with a third sterile swab and the pressure continued, and the pus that next exudes is collected on still another sterile swab, or by means of a stout platinum needle. This pus is employed for the purpose of making coverslip films. Finally, more pus is expressed in a similar way and used to inoculate tubes of nutrient media."

The vaccine should be prepared and used only when general symptoms are present, as it's effect on the condition at the actual site of infection in the mouth seems very variable and on the whole questionable.

We then pass on to the local treatment—first of all, what the patient can do for himself. He can pass silk in between the teeth after meals to remove any débris lodged there. He can use a tooth brush properly, and he should be instructed to massage his gums with his fingers—sometimes with salt, or with tannic acid powder if an astringent is needed. He can do this night and morning at home, and any time during the day, just with his fingers when he feels like it.

What the surgeon can do for him, is first of all to scale—properly—and polish the teeth—this is the longest and most tedious job of all, and at the same time the most important—ionise for two or three sittings—use drugs locally, to make the pockets and surrounding tissues aseptic and then, if possible, get the mouth skiagraphed. This will tell you how far the bone has been absorbed and therefore what teeth will have to be extracted—it may also help in the detection of any tartar that has been overlooked and give a general indication of the state of the roots and the pulps.

Having removed any teeth that are beyond salvation, the pockets may be done away with by means of astringents or operation. You can point out to the patient that he can either come up to you for cleaning and treatment every few weeks of his life, or as long as his teeth last, with the chance of a further infection if he misses for anything more than a month or two, or else he can have a simple operation done now that will make his teeth last as long as anybody else's, and will be all over in a few weeks with slight inconvenience to himself.

But whatever treatment we undertake, we must understand that the matter is not one just for the dental surgeon—nor just between the patient and ourselves; it is a general medical matter—the patient's doctor will be just as pleased to have it cleared up as the patient or ourselves. In fact it is of more importance to clear up the general trouble and give the patient general good health than to do anything else. An edentulous mouth is of comparative insignificance compared with an immovable elbow joint or partial loss of sight. Fortunately the education of the public is better than it was, and most people have a wholesome fear of the disease, and will fall in with any suggested treatment of the condition.

It isn't good enough just to try half-hearted measures of imperfect scaling and syringing now and then. Radical treatment is essential, and a *cure* must always be undertaken—either extraction or the course we have indicated; and the operation on the gum is in most cases the better, as it is a radical cure, and at the same time preserves his own teeth for the patient. We must remember that now, while we are in the Conservation Room, is the time for gaining experience in the various treatments. What we have to do is to form a practical judgment for ourselves on their relative merits and we shall then be better able to deal with a disease which gives our skill its widest scope and the treatment of which is a most important branch of our profession.

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Non-Specific Protein Therapy.

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The trend of modern therapeutic thought has been strongly in the direction of seeking specific substances for the relief or cure of specific maladies, and a great impetus was afforded in this direction by the researches of Professor Almroth Wright; a great part of modern vaccine treatment owes its birth mainly to his work, and so fascinating has been the theory that for every microbic infection it should be possible to devise, manufacture, or obtain a specific "something" which may help the patient to counteract the effects of any particular organism when it attacks him, that there has been for a time a tendency to regard most kinds of vaccine treatment in particular, but also certain types of serum treatment as well, as essentially specific. It is becoming a little doubtful, however, whether the results obtained do depend, as was at one time thought, upon anything so very specific in the vaccine or sera employed; it is at any rate emerging that a non-specific vaccine may sometimes be helpful —and not merely helpful, but almost as good as or even better than a specific vaccine—in the treatment of particular maladies.

To express this idea in a more concrete form —it would formerly have been regarded as useless to employ for a gonococcal infection anything but a gonococcal vaccine, yet it is now clear that some gonococcal affections at least can be much benefited by injections of typhoid vaccine, for example. In other words, the benefits that result from injections of peptone solutions do not depend entirely upon absolutely specific substances in that which is injected, but upon the particular kinds of foreign proteins which these injections may happen to contain. In a similar way Cleland[1] noticed how greatly certain sufferers from fibrositic infections and rheumatoid arthritis benefited as regards their joint and other troubles during the widespread influenza epidemic of 1918—19 when they received—as the greater part of the population did — prophylactic inoculations of blunderbuss influenzal and catarrhal vaccine.

It is because of unexpected benefits derived in this way from injections of solutions of foreign proteins, given for other purposes and not specific for the condition benefited, that the whole subject has received a very wide amount of attention for several years past, and the deliberate use of foreign proteins given by injection for therapeutic purposes is extending, and seems likely to afford an increasing field of usefulness in the direct treatment of various kinds of patients and maladies. The use of specific injections seems to be guided by relatively easy indications so long as the theory holds good that for each micro-organism the substance to be given is to be specific against that micro-organism. The new state of affairs, discovered more or less empirically, leaves one without the guide of direct specific logic, and without some curb there is a very great danger that with the usual swing of the pendulum, associated with the early enthusiasm that new ideas of this kind produce widely both in the medical profession itself and amongst the laity, a great deal more may perhaps be expected from the use of non-specific protein injections for therapeutic purposes than the test of time and experience will prove to be possible; and here, as elsewhere in medicine, it is extremely difficult to sift the true and useful grain from the huge bulk of chaff represented by numbers of immature papers and reports upon the subject that are to be found in the recent literature of other continents besides Europe.

When, however, one begins to think of how cures of microbic and other infections are brought about, one realises that what W. F. Petersen[2] has written upon the subject of non-specific reaction summarises the position very fairly. He says that during the course of the last six years a method of therapy has been developed that seems of interest not primarily because of the clinical results achieved, but rather because this method of therapy promises to exert a far-reaching influence on medical thought and theory concerning the factors that are active in recovery from disease. Since the general profession is still to some extent unfamiliar with the clinical results and the experimental work in this particular field, it may be permissible to discuss briefly two misapprehensions that are commonly current in regard to non-specific therapy: (1) That it represents a new and heretofore unknown and unused method of treatment; (2) That, immunologically illogical, it is purely empiric in character.

At first glance, after thirty years or more of satisafctory effort to perfect specific therapy, it might indeed seem illogical or even a step backward to study non-specific methods of therapy; but if we analyse the subject for a moment we will see that this is by no means true. Let us consider inflammation. We find this reaction fundamentally similar, no matter what the cause of the injury, whether it is bacterial, toxic, chemical, or traumatic. While there may be minor differences in the amount or the composition of the exudate, in the degree of the vascular alteration, or in the type of cellular reaction, the fundamental alterations are always alike. We deal with the effort of the organism to dilute the noxious agent, or neutralise it, to remove it by extracellular or intracellular digestion, and—that failing—to wall it off, to put it outside the current of organ activity. If, now, we seek to alter this process therapeutically, we have two means of approach. The one is interested solely in the cause of the in-inflammatory reaction: if a bacterium, to produce a bactericidal substance ; if a toxin, to produce an antitoxin; if a chemical, to neutralise the chemical agent. We see at once that so far as the causes of inflammation and of tissue injury may be unlimited, our *specific* agents would have to be unlimited also. Our only other possibility lies in the endeavour to alter the reaction of the body, that is, to alter the inflammatory reaction—accelerating or retarding it as may be desirable—rather than trying to alter the agent that has caused the injury. It is at once apparent that here we must deal with substances that have a general effect on cellular activity, with non-specific rather than with specific substances. And from this point of view we are finding that a long list of therapeutic agents, including a great many organic substances as well as chemicals and drugs, have in all probability a common, and pharmacologically a simple, mode of action.

It is probable that every foreign protein when absorbed into the body from the alimentary canal or by subcutaneous or intravenous injection causes one or other of the tissues of the body to produce in retaliation certain chemical substances, differing in different cases, but having this in common, that they would not have been produced if there had not been this ingestion or injection of the foreign protein from without. Even if this is not true of all foreign proteins injected or ingested, it is certainly true of some, and a familiar example is the reaction, shown more by some individuals than by others, after a subcutaneous injection of horse serum. One need not elaborate the symptoms of serum disease, its latent period of about eight days, the way it shows itself when the patient is otherwise quite well—by pyrexia, lassitude, aches and pains in various parts of the body, more acute pains in the joints or muscles, perhaps vomiting, and most characteristically of all by the skin phenomena, especially urticaria. These results come about not in consequence of any "anti" substances, whether antidiphtheritic, antistreptococcal, or antitetanic, contained in the serum, but as a result of the introduction into the living human body from without of the foreign proteins contained in horse serum; and the behaviour of the body fluids or tissues generally is modified, as the result of this reaction to the injection or ingestion of the foreign protein, in a way which is little understood, but which is made use of to help the patient to suffer less than he did previous to the injections; the relief to cases of hæmophilia by this line of treatment being an instance in point. If one knew more about the substances produced in the living human individual in response to the injection of every kind of foreign protein available, one might be able to foretell by logical argument exactly what lesions the patient might be suffering from would be benefited by any particular injection, what conditions would be left untouched, what conditions, again, would be made worse; but our state of knowledge in this direction is so very imperfect as yet, that the discoveries made hitherto have been for the most part accidental, though there has been a semi-scientific thread of thought leading up to some of the discoveries that have been made; and although one would emphasise again — and very strongly — that one has to guard against being carried away by therapeutic enthusiasm, it does seem definitely established already that foreign protein therapy is of real value in certain cases at least in the following groups, each of which may be discussed in a little more detail presently, but which may be summarised as follows :—

1. Asthma treated by intravenous peptone injections.

2. Epilepsy treated by intravenous peptone injections.

3. Arthritis, fibrositis, and synovitis treated by intravenous peptone injections.

4. Subacute long-continued pyrexial infec-

tions (often of obscure origin) relieved or cured by intravenous peptone injections.

5. Hæmophilia treated by horse serum or foreign human serum injections.

6. Purpura treated by serum injections.

7. Desensitisation of persons suffering from food idiosyncrasies by protein injections.

The above seem to have been more or less established as groups of conditions in which non-specific protein therapy has, at any rate in certain instances, been of definite value. If one were to give a complete list of everything that has been recorded by one observer or another as having been benefited in a similar way, one would fill a page, for foreign protein injections are being used at the present time for every conceivable malady, and it is not proposed to advocate them here as yet for certain conditions for which they have been advocated elsewhere, including ununited fractures (Petrault[3]), puerperal septicæmia (Gow[4]), typhoid fever (Miller,[5] Nolf[6]), the arrest of hæmorrhage (Nolf[7]), the prevention of meteorism (Nolf[8]), paroxysmal hæmoglobinuria (Nolf[9]), acute suppuration and healing of wounds (Stracker[10]), adenitis, salpingitis, and mastitis (Carlo Chiaudano[11]), purpura.[12]

1. Asthma Treated by Peptone Injections.

True asthma is to be distinguished from the many other conditions to which the term "asthma" has often been applied erroneously—for instance, chronic bronchitis, cardiac "asthma," renal "asthma," thymic "asthma," uræmic "asthma"; and the peptone injection treatment applies solely to pure spasmodic asthma. This is not a disease, but a recurrent phenomenon occurring in unfortunate individuals who have particular idiosyncrasies, and the idiosyncrasy underlying the spasmodic asthma phenomenon is protean. In some the attacks are apparently due to nerve storms pure and simple, or to intrinsic disorders of the nervous system similar to that which perhaps underlies some cases of Raynaud's disease or other forms of angioneuroses. In others the attacks are due to upsets of the nervous system caused by a great variety of different chemical reactions in the body, and brought on in some as the result of partaking of one or other of a great number of different food substances, in others by the effects of animal products such as dog dandruff, horse manure, particles in the air, and so on and so on. In patient A the idiosyncrasy may be due to some quite ordinary food substance such as yolk of egg; in patient B yolk of egg may be quite harmless, but some out-of-the-way substance such as chicory may be the cause; in patient C it is neither chicory nor egg-yolk, but products derived from cats; in patient D it is due to something else; and there is apparently hardly any limit to the possible substances to one or other of which a particular individual may be susceptible so that as part of his reaction to the intake of these substances he is liable to that type of nerve storm which exhibits itself in the form of a paroxysm of asthma. In some, several different substances may be individually or collectively responsible for the attacks; but underlying the great majority of cases of asthma there seems to be some peculiarity of the chemical reaction occurring in the body as the result of the ingestion of something, either by inhalation or by the mouth. Even if this is too broad and bold a statement, there is in it, at any rate, a great deal of truth; and if only the patient's tissues and intrinsic chemical processes can be altered in such a way that he no longer reacts to the ingestion of these foreign substances in this hitherto untoward manner, he can be rendered less liable than previously to the paroxysmal phenomena of spasmodic asthma, and it sometimes happens that he no longer reacts to them at all and is therefore rendered free from the attacks. It has been found that the injection—generally intravenous—of a solution of peptone sometimes serves so to alter the intrinsic chemical processes as the result of the anti-peptone reaction that ensues in his tissues, that a patient hitherto susceptible to some particular foreign substance liable to cause asthma in him becomes no longer susceptible; and it is in this kind of way apparently that solutions of peptone given intravenously may be of real therapeutic value in the treatment of an asthma case. One cannot say that we have as yet very exact knowledge of what dosage of peptone is the best, nor of just how many injections should be given with the greatest advantage; nor do we know whether the peptone is really the best protein to give, or alternatively whether one gets the best results with peptone by itself or with peptone associated with minute quantities of other proteins of the albumose or proteose types. But it has been established with

fair certainty that it is good treatment in a certain number of cases of true spasmodic asthma to use a 5 per cent. solution of Witte's peptone in normal saline, sterilised, and generally supplied in bulbs ready for use, giving it intravenously with a hypodermic needle and syringe, and using for the first dose 5 min. of this solution, increasing each successive dose by $2\frac{1}{2}$ min. unless or until the dose that is ultimately obtained produces either too marked a general reaction at the time or soon afterwards, or else too pronounced a rise of temperature, *i.e.*, to over 101° F. during the twelve or eighteen hours succeeding the giving of the injection. Until one has further knowledge of the best dosage and frequency, the routine would be to give twelve doses altogether as above, repeating each dose about once every seven days. Sometimes the patient does not even stay in bed at all; but there is often a quite considerable immediate reaction to the injection, with faintness, a sense of tightness in the chest, the development of a feeling of squeamishness or actual nausea or abdominal pain, with blanching of the face, and a tendency to collapse very shortly after the injection has been made, so that it is much wiser for the patient to be recumbent or in bed at the time the injection is given, and for him to remain so until it seems quite certain that there is going to be no reaction of this kind.

Some observers, instead of giving quite small doses of this kind, gradually increased, give rather larger doses and only four of them, or even three; and then the routine would be to give $\frac{1}{3}$ gr. of the peptone dissolved in a few drops of normal saline for the first dose; $\frac{1}{2}$ gr. for the second; and $\frac{2}{3}$ gr. for the third, the repetition being made at intervals of about five days.

It seems highly probable that, when this line of treatment has been investigated further and more is known about it, experience will show that different types of cases may need different strengths of the peptone solution and variable dates of repetition of the dose. That the treatment does sometimes, by its antipeptone reaction within the patient, lead to a very great amelioration of the tendency to attacks of spasmodic asthma, has now been established beyond doubt, though it is very difficult to tell beforehand which case is going to receive much benefit, which some benefit, and which perhaps none at all.

2. Epilepsy and Peptone Injection Treatment.

Even less is known about epilepsy than about asthma, and the relationship of epilepsy to intrinsic chemical peculiarities in the patient is by no means clearly established; but it has long been held by many keen observers that a particular epileptic is more liable to attacks on one kind of diet than he is upon another; exclusion of fish from the dietary will sometimes help one particular patient very much indeed; exclusion of eggs, another; and so on. There is, however, much less clear an association between epilepsy and food idiosyncrasies than there is between asthma and food idiosyncrasies; yet, upon the theory that there is some kind of relationship between peculiar chemical processes in the body of an epileptic and the attacks he suffers from, attempts have now been made in many cases to treat epileptic patients by trying to modify their intrinsic metabolic processes by the administration of foreign proteins in a way allied to that which has been given above for asthma.

It is too early as yet to give anything like a judicial summary of the results, but from what has been observed so far it would seem that there is at any rate something in this line of therapeutics for these patients, and as time goes on one has a feeling that even more useful discoveries in this direction will be made; at all events, in the meantime, when other measures fail to control attacks, it appears that the giving of intravenous injections of peptone is something further than the ordinary treatment that can be tried justifiably in dealing with this disease. Until more work has been done upon the subject it is hardly possible to say what the dosage of the peptone should be, or what the frequency of the repetition of the dose, and one can only summarise the existing very imperfect knowledge by saying that the technique suggested at present is very much the same as that which has been outlined above for asthma.

3. Varieties of Fibrositis Treated by Intravenous Injections of Peptone.

The way in which patients suffering from rheumatoid arthritis, synovitis, fibrositis, and other similar affections showed great improvement in these lesions when they were given large blunderbuss prophylactic injections of influenzal and anticatarrhal vaccine, was apparent

to many during the big epidemic of influenza 1918—19, and the fact has been commented on in detail by Cleland,[1] who saw much of this kind of result in Australia. It was a purely fortuitous result, for the blunderbuss influenza and anticatarrhal vaccines were given not at all because the patients had developed fibrositis or rheumatoid arthritis, but because it became a routine prophylactic treatment for all individuals who had not yet suffered from influenza but who were in the midst of the influenza epidemic at the time.

In a very similar way it was observed again and again during the war that when antityphoid inoculations by T.A.B. had to be given to soldiers even when they were suffering from gonococcal arthritis, the rapidity of recovery from the gonococcal joint troubles was often very remarkably more rapid in those thus inoculated with the T.A.B. vaccine than it was in those with the same malady but without this inoculation being given. Neither the influenzal catarrhal vaccine in the one case, nor the typhoid vaccine in the other, was specific for the fibrositic or arthritic state from which the patient was suffering, yet here were two totally different kinds of non-specific vaccine, each, as it were, fortuitously used, but each bringing about unexpected improvement in the fibrositic and arthritic state. The sequence of events had been discovered in too many countries and by too many different observers for the facts to be controverted; and the question was: How did the improvement from this use of a non-specific vaccine come about, especially in a condition which is always very troublesome indeed to treat and cure?

Extensive investigations led observers to the conclusion that it was no specific antigonococcal or anti-influenzal or antigermal substance in the vaccine that was producing the benefit, but simply the peptone and other allied proteins produced in the culture media upon which the organisms had been grown during the production of the vaccine; and as a test of the accuracy of this view, peptone solutions prepared from commercial peptone have since been utilised in the treatment of certain arthritic states, and though with certain material limitations, none the less with real benefit sometimes. Accident and not logical argument had thus led to the discovery of yet another type of valuable non-specific protein therapy.

It would seem, however, that much has yet to be learned about the culture media upon which the typhoid and paratyphoid bacilli have been grown in the preparation of the vaccine, for some unpublished experiments have shown that the reactionary results may be much greater if extract of ox heart is used, for example, than if horse flesh is the source of the bouillon or other culture medium employed for the cultures. One cannot as yet say which is the very best variety of mixed protein, such as is contained in T.A.B., for the treatment of these arthritic states, but the present tendency is to employ not large doses of non-specific vaccine at all, but simple solutions of peptone in normal saline. One cannot help feeling that a great deal more has yet to be discovered before it can be said that we know what is the best exogenous protein material to use, or what mixture of proteins and proteoses is likely to give the best result; but doubtless some cases of otherwise resistant arthritis, of rheumatoid arthritis type and not necessarily gonococcal, do get very obvious relief from intravenous injections of peptone given in the same kind of way as has been advocated above for asthma, though there is no intrinsic reason why there should not be great latitude in both the frequency of the dose and the mixture of the exogenous protein ingredients employed.

One has no very clear idea of just how the treatment acts, but one can express, in a nebulous kind of way, the thought that the patient, when he thus receives the unexpected and strange protein into his blood-stream, reacts throughout his body tissues, producing anti-protein substances which did not exist there before, and thus as a side-issue produces chemical changes or substances which happen to be inimical to coccal or other infections of his fibrous tissues and joints. One does not conceive that there is any direct action of the foreign protein upon the disease underlying the fibrositis and the arthritis, but rather that the injection of the foreign protein causes the body as a whole to produce substances which it was not producing before, and, incidentally, when these substances are formed, they help the patient the better to throw off the infection from which he happened to be suffering. Anyhow, whatever the underlying theory, the fact is becoming established quite clearly that intravenous injections of peptone do help materially to relieve subacute joint conditions, not only gonococcal, but also when due to other micro-organisms that may be responsible for changes which come under the

headings of fibrositis and infective peri-arthritis.

It has been mentioned above that there are many limitations to the success of the treatment; for example, it is quite clear that when joints have become deformed from the effects of long-standing infective arthritis, they will not when thus disorganised become normal again as the result of the use of peptone solution injections. Pains are not always due to the inflammatory process itself, but often to mechanical disabilities and mechanical pressure upon nerves in the neighbourhood of parts which, having been inflamed in the past, are now no longer inflamed in the ordinary sense, though swollen and distorted. It is not this type of thing for which the peptone injections are good; rather is it in the relief of the active subacute inflammatory exudative process which is the earlier lesion out of which the subsequent deformities and the pains associated with these deformities arise. The earlier, therefore, in a fibrositic or rheumatoid arthritic case, associated with definite and continued but relatively slight pyrexia, that the injections are employed, the greater is the benefit to be expected. If the condition has been present for many months or years, it would only be the changes that had been arising more recently in the progress of the disease that would be alleviated and cured, not the older, more permanent results of previous exudative inflammation. At the same time, it is not a question of merely using peptone injections and getting good results in cases that were going to do well anyhow; for again and again the benefit which patients, who have been ill for several weeks, and for whom various other kinds of treatment have been employed without giving relief, have received almost rapidly from the peptone solution injections, has been so striking that one could not avoid the conclusion that it was the injections themselves that were responsible for the improvement, and that it was really a case of *propter hoc* and not merely one of *post hoc*.

One would reiterate, however, that it is not every patient who benefits in this way, and it would be surprising if it were so, for one is making use of a very ill-defined line of treatment, without any scientific knowledge either of the best form of protein to use in the solution injected, or of the dosage, or of the kind of relationship of the particular protein and its dosage to the kind of microbic infection underlying the individual patient's fibrositic and peri-arthritic changes. The treatment may be tried in many cases without success, but this does not imply that it is not of real value; and if it is only in half a dozen cases out of a hundred that the improvements are obtained which one has now seen time and again, one cannot but acknowledge that in spite of the failures in many, this non-specific protein injection treatment is of sufficient benefit in some to be welcomed and used with discretion fairly widely.

(*To be continued.*)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Labour Party's Hospital Policy.

SIR,—Bias seems to have played a greater part than logic in your review of the Labour Party's policy towards the hospitals.

It does not seem to have occurred, to either the *British Medical Journal*, from whom you evidently drew your inspiration, or to yourself, that because the State has so far not succeeded in unifying its own system of statutory hospitals, there is no reason why it should not do so in the future. You give no reason why it should not have or could not have succeeded in the past.

You write of "The real motive of the whole report" as if the Labour Party attempted to hide its real motive. When the report openly advocates grants to voluntary hospitals on the grounds that they would prove the "thin edge of the wedge" there is surely no attempt to hide its real motive, yet you regard this statement as some form of underhand propaganda.

You admit that increased accommodation is desirable, in spite of the alleged error in the calculation as to the number of beds available, but rather than have State Hospitals to provide this desirable accommodation, you would prefer not to have the accommodation, on the grounds of the burden of taxation. You have yet to prove that insufficient hospital accommodation does not add more to the burden of the overburdened taxpayer than State Hospitals would do.

The Labour Party could only carry out its policy if it had a majority in the House of Commons, your suggestion then that the Labour Party would do it "without any reference to the people who have to pay for it" will not bear inspection. I presume that even you, in your democratic concern for the rights of the taxpayer, would hardly suggest a referendum on the subject of State Hospitals.

I am not a member of the Labour Party nor am I pleading for Nationalisation of the Hospitals, but I would plead, sir, if I may, that when we are offered criticism, in however condensed a form, of such an important document, it be free from the obvious bias displayed in the last "Passim."—I am, etc.,

M. WEINBREN.

Guy's Hospital,
London, S.E.1.

DEAR SIR,—Having by your courtesy been enabled to study at length the pamphlet, issued by the Labour Party and dealt with by you in your last "Passim," I may seem discourteous when I now write to criticise your criticism of the Labour policy. But it appears to me, sir, that you have dealt far too faintly and far too damningly with what is an honest attempt to place a controversial question upon a more certain basis.

The pamphlet appeared to me to have been written carefully and sanely by one who knows hospital life from the inside. Admittedly there are a few exaggerations—possibly inserted for propagandist purposes—but none of them are as flagrant as you would have your readers believe. You scoff at the thought of a hospital day beginning at 2 or 3 a.m., yet an authentic case was reported some months ago in *The Nursing Times* where work regularly began at 3 a.m., and even here at Guy's (as you are doubtless aware) a state of bustle begins about 5 a.m. and certainly continues long after 9 a.m. each morning.

You next venture to say that it is unjust for the pamphleteer to state that an attitude of "servility" is required from nurses by doctors. I would ask you, sir, when next you enter the wards of this hospital to look around you. Even here, in this enlightened age, a nurse's life is one long continued cycle of petty servilities. She is servile to those nurses who are her seniors, and who do not scruple to exact all and more from their juniors than was required of them in their youth. She is servile to the patients, at whose beck and call she remains for long hours every day, and she is servile to the doctors. Do you not realise, sir, that when a house officer enters a ward, it is the duty of all nurses present to stand up, and remain standing in his presence? This for mere houseofficers, mark you, and not for members of the senior staff! Is not this servility? Have you never seen a nurse walk the whole length of a ward to open the door for a houseman to go out? Do you think that she did this for amusement? She may have done it mechanically, but that is only because her sense of servility has become inbred. These are only two examples of the many trivial servilities which you, if you would see, could see, any and every day in this hospital.

Your next injustice to the pamphleteer occurs in your final sentence of this paragraph of yours on the "Anomalies of the Voluntary System." After a short tussle with this extraordinarily badly phrased sentence one came to the conclusion that you meant to insinuate that the pamphleteer accused nurses of being unsympathetic towards their patients. What the pamphlet actually says is—"In order to get through necessary work with the inadequate staffs at present allowed . . . it is impossible . . . for nurses to pay regard to the mentality of the individual patient, and a general brisk cheerfulness takes the place of any real sympathy or understanding." I think that there can be no disputing this statement when qualified in this manner. An example of this absence of real understanding and sympathy which exists among both nurses and students is the objectionable though universal practice of referring and speaking to patients by the number of their beds and not by name. Is not this evidence enough that little trouble is being taken to be genuinely sympathetic?

Your next paragraph condemns the Labour Party *without trial, merely because in the past*, governments set up by other parties have not been able to keep their institutions from stagnation.

But it is in your penultimate paragraph that you make your most unjustifiable statement, when you accuse Labour of trying to foist an expensive project upon the country "without any reference to the people who have to pay." This shows how little you have realised the whole purport of this pamphlet. The Labour Party has come out into the open and said, if you will give us power we will do so and so for the hospitals. The whole pamphlet is meant to be Labour's reference "to the people who have to pay." If these people think as you do—that the expense of the policy is not justified by the end in sight—they will not return Labour to power.

Whatever happens, however, in the future, I think it is obvious that such an open declaration of a policy, however fantastic or Utopian, ought to be encouraged. Let us not malign the Labour Party because their scheme seems too grandiose, but let us ask the other political parties to come into line and state what they will do if they are given power in the land.—Yours sincerely,

A. T. ROGERS.

Guy's Hospital,
London, S.E.1.

Appointment.

W. R. Reynell, M.D. Oxon., M.R.C.P. Lond., appointed Physician (with charge of Out-Patients) to Royal Northern Hospital, Holloway.

When the "Gazette" was Young.

(*Continued*).

A Dramatic Coincidence.

Another remarkable occurrence I witnessed in the theatre. John Birkett, the next in seniority to Cock and Hilton on the surgical side, was looked on as the greatest authority of his day, in all "breast" cases. For reasons which need not be here stated, there was intense "coolness" between him and Bryant. On the same Tuesday, Birkett was down for an operation for "mammary tumour," and Bryant for "mammary schirrus." At the appointed time, Birkett, who ought to have operated first, was not there, so Bryant commenced, and whilst the patient was being put under the anæsthetic, he dilated fully on the case and pointed out the salient features by which he recognised it as "cancer." As his book was then the leading text book on surgery he was listened to with great attention. As soon as he began to speak, Birkett had come into the theatre and so heard the whole of his remarks. The breast having been removed and the operation completed, an incision was made through the tumour, showing it to be a gland thickened and hardened by chronic inflammation, but not a trace of cancer.

As Birkett had entered the theatre whilst Bryant was speaking, he had, of course, been witness of the *dénouement*. When he was addressing the students on his own case as she lay on the table, he said, "Although I have diagnosed the case to be simply chronic mastitis, the results of the operation which has just left the theatre, show us how liable we are, in all breast tumours, to mistake their nature, I will content myself with Dupuytren's diagnosis, who would only say, *before* the operation, '*Nous verrons*,'" in speaking of breast tumours. The gland was removed and showed itself to be an advanced schirrus.

The occasion was remarkable, as showing in a most graphic manner, the almost impossibility, at times, in distinguishing between a breast indurated by chronic inflammation, and true schirrus. I have seen the mistake made over and over again, but never in such a striking demonstration, and keenly accentuated by it being the only instance in which I ever heard or saw either Birkett or Cooper Forster make any sign or look that they were ever aware of the presence or existence of Thomas Bryant.

A "Bleeder."

I have only seen one case of hæmophilia in my life, and that was about this time in "Accident" Ward. He came in for a compound fracture of the left tibia and fibula, the skin wound being but small. The bandages became soaked in blood, so a compress was put on, and though gradually made firmer and tighter the dressings were soaked through just the same. Under the impression that it must be due to a vessel that required tying, Durham enlarged the wound and sought the vessel. No special vessel was seen, but blood oozed from hundreds of minute orifices. One by one these were ligatured, and the ends left long, (we were then only just out of the sixties), until the gaping wound exactly resembled a housemaid's brush. Then twisting the vessels was adopted. How many were twisted it is impossible to say, but at length we left off from sheer weariness, the blood flow apparently not much benefited. A firm bandage and compress was then applied and the leg elevated. What hæmostatics were used I cannot now say, but nothing had any effect. His blood became thinner in consistency and paler in colour, but oozing went on in a most relentless fashion. I was with him so continuously that I was almost worn out. At length gangrene set in and he sank.

In our anxiety and eagerness to arrest the bleeding, there were no elaborate details of family history taken, that was left to the Ward Clerk. We were too much in need of rest, at his death, to trouble about it then, but an accurate family history, as well as his past personal history, would be very interesting. I never wanted to see such another. I have since had to treat youths who were popularly said to be "bleeders," but all such responded at once to very simple measures, although a naked wound would certainly go on trickling, if unattended to, for a long time. I have never seen anything fit to be compared to the above.

The "Bermondsey Murder."

It was also about this time that a man named Taylor was admitted for a fracture of the skull. We could never get any account of

how it happened. His head was seen to be wounded and bleeding, so he was brought to the hospital. This was all that could be gathered from himself and others. On examination there was found to be a depressed fracture of the vault of the skull, evidently made by some round instrument about the size of a halfpenny. It was as clean cut as though it had been done by a trephine. The broken fragment was quite entire and was easily lifted up. This must have been done by a pretty smart blow with a round-faced hammer, but the perpetrator would not come forward to acknowledge it.

Taylor was the unfortunate hero of, what was known for a long time as, the sensational "Bermondsey Murder." The wound was inflicted in a scuffle while he was being secured. I think he had killed his wife and all his children. This was the report, but whether it was "all" or only "several," I am unable to say, but it was a horrible tragedy and created for a time a profound sensation. He was subject to sudden attacks of homicidal mania, and it was during one of these attacks that the crime was committed. He ought to have been in prison and under strict police supervision, but he was not; nor was there any policeman in attendance upon him during his stay in the hospital. During the intervals he was a very quiet peaceful man, showing no trace of the fearful malady from which he suffered. He was an inmate for some time, and was of great use in helping the nurses to perform their duties. Every day he might be seen at the same hour fetching the patients' beer in one of the huge copper costrels used for the purpose. He roamed at will, doing these various duties, in different parts of the buildings and grounds.

A Stampede of Paralytics.

One day, however, in Petersham Ward, on the first floor, he developed another attack. It came on him like an epileptic seizure, but instead of producing paralysis and insensibility, it developed again as homicidal mania. Petersham was then a medical ward and in it were several patients with para- and hemiplegia. The first thing Taylor did was to seize the long hanging chain and weight of the ward clock. Swinging this formidable weapon round his head he went from bed to bed, attacking nurses and patients alike. Those who could, fled; one nurse jumping out of the window and breaking her leg. Most of the paralytics got out of his way, some escaping very quickly and nimbly. He was eventually secured before he was able to destroy any life. But it seemed to us then a monstrous dereliction of duty, to allow a man, with such a frightful form of insanity, to be even for one moment without an adequate guard. Evil is almost certain to follow any negligence in this respect, and I have justification in saying that this severe and deceptive complaint is not looked at and regarded with the attention it deserves even now.

Epileptiform Mania.

There was another man similarly afflicted, admitted shortly afterwards. What his complaint was I do not remember, but he was known to be an "epileptiform maniac," and was, as such, put in what was known as the "strong room." It was a basement apartment situated close to the steps leading down into the "Park" on the Maze Pond side, one of the men servants was always with him on guard. In those days, after lunch on Sunday, we used to take our chairs into the Colonnade and watch the hundreds of visitors pouring through the barrier to visit the patients. It was an interesting sight and one charged to the full with the realities of life and the struggle for existence. One Sunday, as we still occupied our chairs, when the Colonnade was again quiet and empty, one of the bathmen walked down in company with another man not known to us. He was such a powerful, well-built looking athlete that we walked across to the porter's lodge and asked who Hunt's companion was. Hunt himself was a strong young man, but he looked small when compared to his companion. Little, the gatekeeper, said I don't know his name, but he is a prize fighter. He looked like it.

That evening as we sat, after dinner, talking, the strong-room nurse burst into the room, and, pressing her hands on her breast, called out, "Oh, my heart!" and collapsed on the floor. Without waiting to inquire about her heart, guessing what was the matter, we rushed off bodily to the room where the man with homicidal mania was being guarded. What we saw was the patient standing on his feet, with his body flexed at the hips and his arms forcibly extended to the ground. Lying still and motionless on the floor, were two men, one on each side of his feet. His two hands were

grasping the throats of these men and pressing them down upon the boards. They were evidently pretty far gone in asphyxia, for they lay on their backs motionless and still. One of us, named H. Williams, immediately grasped the maniac so painfully that his hands at once released their hold on the throats of his victims. He was secured, and his attempted double murder happily averted. The two men on the ground were those we had seen that afternoon walk down the Colonnade, Hunt and and the prize-fighter, who, it seems, had come to keep him company during his vigil.

NERVOUS ENERGY.

The patient himself was a slight, and comparatively puny, man, with anything but a muscular body. How he came to get two strong men so completely into his power was never explained, for the two men said they did not remember any other detail beyond the bare fact that he sprang on them, and that was all.

It was long before Williams ceased extolling the virtues of his method and his discrimination in selecting the proper manner of dealing with desperate emergencies. It was a near shave. It serves to show that "strength," or what is known as "muscular strength" does not lie in the bulk of muscular tissue, but in the force of the nervous current that is discharged into those muscles. It is evident that in mania and epilepsy and other nerve storms a much greater energy is developed, or released by, or from, our dynamo than usual, or possible, in the normal conditions of storage.

Some years after this I was consulted by a man who had just returned from hunting. He was a man of altogether exceptional qualities relating to his nervous system, in regard to endurance of fatigue and energy of action, but into this we need not enter. He always took care to ride the very best hunters that he could find, and certainly some of them were wonderful performers. On this particular day, his horse, a powerful animal, was just in the act of "taking off" on, what flashed on him suddenly was, a dangerous leap. Putting all his strength into his left arm he succeeded in checking the animal. For the rest of the ride that arm was useless. When he came to me I found the flexor muscles of the forearm to be collected into two lumps, one just below the elbow, the other an inch or two above the wrist. Between them was a gap into which my fore- and middle-finger, laid across the arm, seemed to rest directly on the two bones, just filling the gap in height. He had torn the whole of the flexor muscles completely in two. For years after there was a well-marked ridge, which gradually disappeared.

By many, this man was called "mad," but it was only true in a modified sense, and related more to the extreme nervous force he would put into somewhat indecorous acts.

A UNIQUE REFLEX.

It is singular also that *all* liniments of the pharmacopœa, belladonna, chloroform, opium; every one, without exception, produced on his skin such a violent eruption of eczema that the serum from the vesicles would run down the skin in little trickles, and soon soak any dressing that was applied. The only one application he could bear was a mixture of ether and other things which was prescribed for him by a bonesetter of very great local reputation. This soothed local pain a little, but it certainly did not cause eczema. I think I never saw such fiery and acute dermatitis, as such a liniment as tincture of belladonna would set up after one application.

(*To be continued*).

Notices.

Guy's '89 Club.

The following Members have already notified their intention to be present at the forthcoming Dinner:—

H. W. Beach, F. S. Brereton, Cecil Carpmael, H. W. Collier, C. D. Edwards, John Ensor, C. A. Ensor, R. H. Fagge, W. Lampson Handley, W. J. Henson, A. C. Hovenden, Bradney Instone, H. Milbank-Smith, H. A. Munro, B. G. Reynolds, L. G. Reynolds, W. E. Robinson, E. T. Shorland, F. J. Steward, H. M. Stewart, Wilson Tyson and G. Leslie Eastes.

Beaney Prize for Pathology.

This examination will be held on Monday, May 8th, at 10 a.m.

Entries should be handed in to the Medical School Office not later than Monday, May 1st.

The Treasurer's Gold Medal for Clinical Surgery.

The examination for the Treasurer's Gold Medal for Clinical Surgery will commence in the Committee Room adjoining the Medical School Office, on *Tuesday, June 6th*, at 10 a.m.

Candidates desirous of competing for same must forward their application to the Medical School Office not later than *Monday, May 29th.*

Application forms may be obtained from the Medical School Office.

April 1922.

The Treasurer's Gold Medal for Clinical Medicine.

The examination for the Treasurer's Gold Medal for Clinical Medicine will commence in the Committee Room adjoining the Medical School Office. on *Tuesday, June 6th,* at 2 p.m.

Candidates desirous of competing for same must forward their application to the Medical School Office not later than *Monday, May 29th.*

Application forms may be obtained in the Medical School Office.

April, 1922.

Junior Guyite Club.

The 36th Dinner of the Junior Guyite Club will be held at the Restaurant Frascati on the third Thursday in May (18th), Lt.-Col. S. E. Prall, president.

Dr. J. G. Porter Phillips has very kindly offered to arrange for vocal and instrumental music on that occasion.

Every member of the Junior Guyite Club has the privilege of introducing any qualified Guy's man as his guest on the 18th May.

Guy's Hospital Ladies' Association.

A Garden Fête will be held by the Ladies' Association in the Grounds of Guy's Hospital (by the kind permission of the Governors) on Thursday, June 29th, from 3 to 9 p.m.

There will be Stalls for the Sale of Garden Produce, Provisions, Household Articles, Children's Clothing, Plain and Fancy Work, Flowers, Walking Sticks, Baskets, Cakes and Sweets, also a Second-hand Stall, for Books, China, Glass, and Gramophone Records, etc.

Dancing in the Nurses' Home.

Various Side Shows.

Tea and Ices.

A Band will play in the Grounds during the Afternoon and Evening.

Admission to the Fête 1s.

All past and present Guy's men, sisters, and nurses are cordially invited to attend and to bring their friends.

Contributions to any of the Stalls will be most gladly welcomed, and should be sent, not later than June 21st, marked "Garden Fête," to The Matron's House, Guy's Hospital, S.E.1.

Gifts of Perishable Produce or Flowers should be sent to The Matron's House, early on the Morning of June 29th.

The name and address of the Donor should be sent.

MABEL G. BONSOR.

All enquiries should be addressed to:—Hon. Secretary, G.H.L.A., 73, Wimpole Street, W.1.

Suggestion and Mental Analysis.

The University of London Press, Ltd., announce the very early publication of a popular volume on "Suggestion and Mental Analysis" by Dr. William Brown, Wilde Reader in Mental Philosophy in the University of Oxford, and Author of "Psychology and Psychotherapy." The book is a brief and elementary summary of modern methods on mind cure and comprises an appreciation and criticism of M. Coué's views indicating their relation to other methods of suggestion and doctrines of Psychanalysis.

Lectures on Insanity.

Sir Maurice Craig will meet all students desirous of attending the Summer Course in Insanity in the Clinical Theatre on Friday, May 5th, at 9.30 a.m.

Lectures will be continued regularly every Friday, at the same time and place until further notice.

It is important that all students who intend entering for the Final on or before July, 1923, should take this course.

Lectures in Operative Surgery, Forensic Medicine, and Public Health will commence during the first week in May. Dates will be announced later.

The Clinical Course at Bethlem will be on alternate Tuesdays and Thursdays as follows:—

Tuesday, May 9th.	Thursday, May 18th.
,, ,, 23rd.	,, June 1st.
,, June 6th.	,, ,, 15th.
,, ,, 20th.	,, ,, 29th.

Denis Astley Sanford.

The following is a copy of the appeal which has been sent to the Governors of Epsom College, in support of the claims of Denis Astley Sanford, to admission to the College.

Election, 1922.—Your votes and interest are respectfully solicited on behalf of Denis Astley Sanford, aged 9 years, son of Harry Archibald Sanford, M.B., B.S., Lond., M.R.C.S., L.R.C.P. (Guy's Hospital), who died in 1918, aged 33 years, after 5 years' illness, leaving his widow and son in straitened circumstances.

The case is recommended by:—

H. L. Eason, Esq., M.D., C.B., C.M.G.
John Fawcett, Esq., M.D., F.R.C.P., F.R.C.S.
H. French, Esq., M.D., F.R.C.P., C.B.E.
W. G. Gaussen, Esq., M.A., B.D.
C. Poulett Harris, Esq., M.D.
Sir Frederick Mott, K.B.E., M.D., LL.D., F.R.S.
R. P. Rowlands, Esq., F.R.C.S., O.B.E.
Sir J. Charters Symonds, K.B.E., C.B.
The Bishop of Warrington.

Pass List.

Royal College of Surgeons.

L.D.S. FINAL EXAMINATION.

H. K. Banks.
D. C. Eglinton.
G. B. Kempster.
D. A. Parsons.
E. Samuels.
F. W. Watt.
E. C. Bevis.
L. G. Gray.
R. V. Kenroy.
C. M. A. Pauw.
G. H. Smith.
P. H. Williams.
G. Curle.
G. G. T. Haynes.
M. Lewis.
P. Pienaar.
W. A. Strickland.
T. L. Winn.
A. B. Daneel.
L. G. Hemmings.
S. Masey.
V. F. Pilbeam.
P. G. Trafford.
K. W. Eady.
R. Hughes.
S. P. Meacock.
J. D. P. Roberts.
P. J. Walters.

Reviews.

Functional Nervous Disorders. Donald A. Core, M.D.Manc., M.R.C.P. (Messrs. John Wright & Sons. Ltd.) Price 25s. net.

At the outset of this work the author attempts the difficult task of putting a definition to the most complex branch of modern medicine. Functional nervous disorders are to be regarded as "the expressions of abnormally controlled emotional reactions, determined and adjusted by environment and not by any gross or demonstrable pathological lesion."

The definition is open to criticism, however, because it takes too superficial a view of the subject, failing to embody any reference to the deeper underlying factor or factors which are the invariable activators in such disorders.

The author proceeds to explain that the abnormality in reaction is not qualitative but quantitative, the real mechanism at fault being the restraint of the emotional tone. Few could agree with this statement, for amongst the countless patients suffering from functional maladies there is a definitely recognisable minority in which not only is the emotional reaction unrestrained, but also it is diametrically opposed in character to that which would be expected in the normal individual.

In general the book is good, particularly worthy of mention being the section on the obsessive mnemo-neuroses, and should grove of value to those engaged in the study of medical psychology.

Change of Address.

Percival S. Campkin, 30, Queen Anne Street, Cavendish Square, W. 1.

Erskine Faraker, M.R.C.S., L.R.C.P., Medical Officer, U.F.C. Mission Hospital, Kalna, Burdwan District, Bengal.

A. Hammond-Smith, 1, Highbury Place, N.5.

Powis Conway-Jones, L.D.S., R.C.S.Eng., Bedford House, High Street, Bognor.

Capt. G. E. L. Simons, R.A.M.C., 48, Crystal Palace Road, Sydenham, S.E. (Formerly of Aden).

Percival C. Campkin, 30, Queen Anne Street, Cavendish Square, W.1. ('Phone Langham 2032.)

Papers by Guy's Men.

R. Davies-Colley, M.Ch., F.R.C.S. Slipping Rib.—*Brit. Med. Journ.*, 1922, 1., p. 432.

John W. H. Eyre, M.D. and A. I. Simey. Restriction of Influenza Epidemics in Schools by the Use of Local Prophylactic Vaccines.—*Ibid.* p. 433.

Alan H. Todd, M.S., B.Sc., F.R.C.S. Hunterian Lecture on Orthopædic Aspects of Rheumatoid Arthritis.—*Lancet*, 1922, i., p. 515.

Arthur F. Hurst, M.D. The Hysterical Nature of So-Called Pernicious Vomiting of Pregnancy.—*Ibid.* p. 528.

Birth.

MORLAND SMITH.—On March 17th, at the Hive, Exeter Road, Bournemouth, the wife of Dr. T. Morland Smith, of a son.

Marriage.

VICKERS—MUMMERY.—On April 24th, 1922, at S. Barnabas, Pimlico, by the Rev. G. W. Hockley, Rector of Liverpool, Thomas Vickers, Chaplain of Dar-es-Salaam, T.T. East Africa, to Margaret Celia Mummery, daughter of J. Howard Mummery, Esq., C.B.E., D.Sc., of 79, Albert Bridge Road.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

VOL. XXXVI., No. 883.] MAY 13, 1922. [NINEPENCE.

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Passim.

THE many admirers of Dr. P. P. Laidlaw will hear with great regret that he is leaving the Hospital, and there is little doubt that a few details of his connection with Guy's will prove of interest.

Dr. Laidlaw came to Guy's in 1904 with an entrance scholarship, after he had taken his B.A. degree at Cambridge with a first class in Parts I. and II. of the Natural Science Tripos. In 1907 he qualified with the B.C.Camb., and was Clinical and A.H.S. to Mr. Fagge; then for two years he was Demonstrator of Physiology until 1909, when he left Guy's to take up a research post at Wellcome's Physiological Research Laboratories. In 1913 he returned to Guy's on appointment to the Gordon Lectureship in Pathology, and became the first holder of the Sir William Dunn Lectureship in Pathology, when it was established.

Distinguished by his wide and critical knowledge of pathology, pharmacology, and physiology, to each of these branches of knowledge he has made valuable contributions. He was ever ready to place his stores of knowledge at the service of inquirers both within and outside Guy's, and we have all learnt a great deal from his contributions to the discussions at meetings of the Physical and Physiological Societies.

Few who have met and known Dr. Laidlaw are likely to forget his personality. Whatever new work he may undertake in the future, all his friends at Guy's will unite in expressing the hope that success will attend his efforts.

THIS number of the GAZETTE is a Special Publishers' Number, and on glancing through reviews or the lists of books which are contained in the various Publishers' Announcements in our advertisement pages, one is impressed by the enormous number of new books on medical subjects which are being printed every year.

Single diseases, or operations, for the discussion of which a few pages, or at most a chapter, were at one time considered sufficient, are now the subject of exhaustive monographs and treatises. And the more highly developed our profession becomes, and the more our specialised knowledge progresses, the more necessary will it be for the medical man to possess an adequate library of books dealing with subjects he must know thoroughly.

Osler has said that the medical practitioner who wishes to keep up-to-date should do so by a study of medical periodicals. And there

can be no question that this is essential. But there are some books that every practitioner or student needs for reference and for study.

If one were to buy all the books one would like to have, one would be compelled to indulge in a positive orgy of acquisition, which would probably end in insolvency. And the time-honoured method of borrowing from a friend and forgetting to return the volume leads to recriminations and unpleasantness.

It is possible, however, to adopt a middle course. Consult some books in libraries, borrow some from friends, review some if possible, and buy those books which it is essential to possess.

We offer our hearty congratulations to Mr. S. H. Croucher on his election to the Chairmanship of the Penge Council. Not many of the students to whom Mr. Croucher is such a well-known figure, are aware of his activities outside the Hospital. In 1913 he was elected a member of the Council, but he had served, as a co-opted member, on the Education Committee since 1903, and for some years was Chairman of this Committee. During four of the nine years he has served upon the Penge Council, Mr. Croucher has acted as Chairman of the Public Health Committee, and he was responsible for the introduction of the Maternity and Child Welfare Clinic, which has done such good work in the Penge district. He also took a leading part in the formation of the School Dental Clinic and the scheme for the treatment of minor ailments amongst school children. He has been Chairman of the Penge and Anerley Philanthropic Society, and has served for some years upon its Committee.

As Chairman of the Penge Council, Mr. Croucher becomes a Justice of the Peace.

The Guy's Hospital Annual Ball, which was held at the Prince's Galleries on Friday, April 28th, may be considered to have been a great success as a social function. Unfortunately the financial aspect of affairs is not so encouraging. In spite of a substantial reduction in the price of tickets, the Ball was not so well supported as in former years. Short notice undoubtedly prevented many of the Staff from attending. This is a pity, as no dance could have been more enjoyable, all the arrangements being exceptionally good.

Owing to lack of support, however, the subscriptions received did not cover the expenses incurred in the management of the dance, with the result that the Residents' Fund, which has not yet recovered from the heavy cost of the Theatricals, has a further liability to meet.

In connection with the Combined Appeal organised by the King Edward's Hospital Fund, an "Empire Flag Day" in aid of the Hospitals will be held on Empire Day, May 24th. This Flag Day is being run by the Order of St. John and British Red Cross Society. Guy's men will have an opportunity of participating in this work, as the Medical School will be closed on May 24th, and arrangements are being made for students to assist in the collections. The Matron, in view of the special nature of the occasion, has given permission to Sisters and Nurses to sell Flags in uniform. As far as we are aware, this is the only occasion upon which such a step has been taken.

We cannot help feeling that a combined appeal, such as this, on behalf of all hospitals, is infinitely more satisfactory and dignified than appeals for individual institutions. It deserves the whole-hearted support of all who are in any way connected with hospitals. The adoption of co-operative methods of raising funds constitutes a step forward in our progress towards sound economic conditions, and we earnestly hope that all who can help on May 24th will do so in every possible way.

We hear with deep regret of the death of Sir Henry Davy, which occurred at Exeter on May 10th. Sir Henry Davy, after a highly successful academic career at Guy's, followed his profession with distinction throughout his life. The author of several books upon medical subjects, he also contributed many articles to medical journals. In 1907 he was President of the British Medical Association. At the

time of his death he was Consulting Physician to the Royal Devon and Exeter Hospital and the Southern Command. By his death the profession loses a most distinguished member, and the Hospital one of whom it has every reason to be proud.

We have been asked to draw attention to the Mixed Doubles American Tennis Tournament (Handicap), which will be held on Whit Monday, June 5th, at Honor Oak Park, in aid of Sir Arthur Pearson's Fund for Blind Soldiers, and the Fresh Air Fund for Poor Children. Fuller details are posted in the Colonnade.

The small number of entries for the Hospital Sports has moved the Secretary of the Athletic Club to write an appeal which will be found in the correspondence columns of this issue. It is certainly surprising to find that there are not more entries in so large a School. We hope that the paucity of names at present on the board in the Colonnade may be attributed to hesitation on the part of students as to their choice of events, and not to reluctance to compete.

There are many reasons why a large number of men should compete in the Hospital Sports this year. In the first place, if the Inter-Hospital Athletic Shield is to be won by Guy's, it is essential that the best athletes in the Hospital shall represent Guy's in the Inter-Hospital Contest. The team for this meeting will be chosen from those who are successful, or show good form, in the Hospital Sports.

The Inter-Hospital Competitions will be held at Queen's Club on June 10th. It is anticipated that the meeting, which will be managed and advertised by the Hospitals' Appeal Committee, will be an exceptionally big one, attended, as our journalistic contemporaries might express it, by a large and fashionable crowd. This makes it more desirable than ever that Guy's should produce the successful team.

The alteration in the date of the Hospital Sports from Wednesday, May 24th, to Tuesday, May 23rd, is due to the fact that a Hospital Flag Day has been arranged for the former date. This fact should not affect the number of competitors if due recognition is accorded to it by the authorities, as no doubt it will be.

The Secretary of the Athletic Club has also asked us to draw attention to the University of London Athletic Sports, which will be held on May 27th. There is no limit to the number of entries from each hospital. Entry forms can be obtained from Mr. A. S. Gough.

Footballers are reminded that the Annual Dinner of the combined Rugby and Association Football Clubs is to be held at Oddenino's Restaurant on May 17th.

The Football Dinner is one of the pleasantest re-unions of the year, and is usually very well attended. Not the least of its attractions is the anecdotal tone which usually pervades the after-dinner speeches.

The 1922 Edition of the University of London Union Magazine has now been issued. Its object as the organ of the University of London Union Society is to foster a spirit of unity between the various Colleges and Hospitals of the Universities, to help to create a community of feeling among students of the University, to "facilitate the fertilising contact of mind with mind"; to "build up a University life . . . and to supply that social education without which academic learning is but barren."

There is no doubt that medical students—to take one specific group of London undergraduates—suffer a certain isolation. They meet other medical students, and medical students alone. Their acquaintances do, sometimes, include men from other hospitals, but it is seldom that they meet students of a subject which differs from their own. We can not but applaud an effort to bring about a *rapprochement* between the various Colleges of the University, but it is to be doubted if a real corporate University life will ever become an established fact in the sense that men will consider themselves, in sentiment at least, as

London University men first, and as members of their Hospital second. Local Hospital traditions are too strong, and the London Schools are too widely scattered. Nevertheless, any attempt to bring London University men into contact with one another is to be welcomed.

The literary standard of the magazine is high. Among the many interesting articles it contains are one by Professor Elliot Smith and a contribution from the pen of E. V. Lucas.

The magazine may be obtained from the Wills Librarian (price 1s.).

Old Guy's men who are interested and would like a copy can obtain one for 1s. 3d., post free, on application to the Editor of the GAZETTE.

Events of Interest for Fortnight ending May 27.

May 15.—1.30 p.m., Clinical Lecture by Mr. Chapple.

May 17.—1.30 p.m., Clinical Lecture by Dr. Poulton on "Visceral Pain: the diagnosis of lesions in the alimentary tract."

May 18.—4 p.m., Dr. Sington on "Some practical points in Anæsthesia," at the Hospital for Sick Children, Great Ormond St.
5 p.m., Major-General Sir W. B. Leishman on "Enteric Fevers in the War," at St. Mary's Hospital, Paddington.

May 19.—4.15 p.m., Mr. Russell Howard on "Acute Intestinal Obstruction," at the London Hospital (Clinical Theatre).

May 22.—1 p.m., Clinical Lecture by Mr. Mollison on "Complications of Otitis Media," in the Clinical Theatre.

May 23.—2.30 p.m., Hospital Sports at Honor Oak Park.

May 24.—1.30 p.m., Clinical Lecture by Mr. Hughes on "Some Cases of Gangrene."

May 25.—4 p.m., Mr. Fairbank on "Flat Foot," at the Hospital for Sick Children.
5 p.m., Prof. E. H. Starling on "Some New Experiments on the Kidney," at St. Mary's Hospital.

May 27.—2 p.m, University of London Sports at Queen's Club.

Appointments.

W. Arthur Young, B.Sc., M.B., B.S., Pathologist to the Royal Chest Hospital, City Road, E.C.

J. V. C. Braithwaite, M.B., B.S., M.R.C.P., Assistant Physician to the Leicester Royal Infirmary.

Swimming Club.

Although Hospital Clubs, as a whole, have shone in most branches of interhospital sport the record of the Swimming Club for 1921 is certainly one of the most gratifying. To describe the season in terms of results, we carried off the Inter-Hospital Diving, Swimming, and Water Polo Cups, and the University Water Polo Cup, and the Nurses captured their Inter-Hospital Cup.

This season promises to be a very keen one and it will be up to us to overcome much stronger opposition than we encountered last year. In addition to the competitions for the Cups already mentioned, there is the lately organised Inter-Collegiate Team Race of six aside to be held at the University of London Gala. This event will test us severely.

A fixture list has been arranged for second Water Polo and Swimming Teams, and this, together with many open events at the United Hospitals and University Galas will afford ample opportunity for the working off of superfluous keenness. We would remind keen men that there are vacancies for good swimmers in the Guy's, United Hospitals and University Teams.

The fixture cards for the Hospital Summer Sports are now ready and swimming men will see that only keen support is necessary to make the season an unqualified success.

The Committee hope that all keen men will make a point of attending the practices. These are held on Tuesdays and Thursdays at the lunch hour, between noon and 2 p.m., in the Hospital bath, and on Mondays and Wednesdays at Lavington St. Baths, Southwark.

The following fixtures have already been played:—

GUY'S v. OLD DUNSTONIANS.

On Friday, May 5th, 1922.

Team Race (4 aside).—Guy's won easily.

Guy's Team.—Schofield, Bekker, Dingle, Richards.

Polo.—Our team was beaten 3—1.

Guy's Team.—Bekker, Harvey, Wakeford, Cohen, Hutchinson, Theis, Brown.

GUY'S v. ST. PAUL'S SCHOOL.

On Saturday, 6th May, 1922.

Diving.—Guy's were beaten 10 points to 12.

Guy's Diving representative.—G. Cohen.

Swimming.—Guy's won this event, after a keen struggle.

Guy's Swimming Team.—Schofield, Dingle, Theis, Hutchinson, Harvey, Richards.

Water Polo.—Guy's won 5—0.

Guy's Polo Team.—Simons, Wakeford, Harvey, Cohen, Hutchinson, Brown, Theis.

Non-Specific Protein Therapy.

HERBERT FRENCH, M.D., F.R.C.P.

[*By kind permission of* THE MEDICAL ANNUAL.]

(*Continued.*)

4. SUBACUTE AND LONG-CONTINUED PYREXIAL INFECTION OF OBSCURE ORIGIN CURED BY PEPTONE INJECTIONS.

One meets now and then with patients who are out of sorts without being absolutely ill, and who, when observed continuously, are found to have continuous pyrexia of a type which might suggest subacute infective endocarditis or a continued infection from coli bacilluria or some affection of that sort, and yet who, in spite of extensive hæmatological and bacteriological investigations, baffle exact diagnosis. They give a negative tuberculin reaction, and, though causing much anxiety for a time lest after all they should prove to be tuberculous, or the subjects of infective endocarditis or of some other fatal malady, yet nevertheless by not dying they seem to prove that their infection, whatever it is, is relatively mild even though so persistent.

The patients referred to may not be numerous, and it is difficult to define exactly the class of thing meant, but we all meet with them from time to time, and one becomes more and more at a loss to know what treatment to advocate and carry out, for whatever is done in the ordinary way seems to have no influence upon the continuation of the pyrexia and chronic ill health. Doubtless these patients are not all infected by the same micro-organisms, and if we were yet more successful we should elucidate the bacteriological cause of their complaint; but from a medical point of view the question which does arise is: What can one do next to cure this patient?

Peptone injections given intravenously, and sometimes even only two injections of 5 c.c. of a 5 per cent. solution, will occasionally alter the whole course of things completely, and without any apparent rhyme or reason the patient thereafter begins to feel better, eats better, loses the pyrexia, and makes a definite and often rapid recovery. It is more than likely that foreign proteins injected intravenously in this way might help to modify for the better and cure much more serious infections; and they have been advocated even in the course of acute post-puerperal septicæmia. One feels, however, less confident in advising them in patients who are already acutely ill, at any rate until more experience has been gained. When, however, the patient is not so seriously ill and not in any apparent danger, one feels that the giving of peptone injections in this way in small repeated doses is safe, and the fact that some at least of the patients are so much benefited by them when other measures have failed, shows that it is a therapeutic measure which can be definitely advocated.

5. HÆMOPHILIA TREATED BY INJECTIONS OF NORMAL HORSE SERUM.

Although a good many dogmatic statements have been made as to the exact pathology of hæmophilia and the diminished clotting power of the blood that is associated with it, we do not really know precisely what the error in the blood condition is that a hæmophilic patient has inherited; but that it is due to some variety of abnormality in the intrinsic chemistry of the blood is probable. If the injection of foreign proteins into an individual leads, by reason of the antiprotein reaction which results, to alterations in the intrinsic chemistry of the individual, it should be possible by means of some such injection so to change the chemistry of the hæmophilic's blood as to make him a sufferer from his disability in a greatly diminished degree, or even to cure his disability altogether. Many attempts have been made in this direction, and perfection has not yet been attained, but there is no doubt about the value of injections of exogenous serum in the treatment of the condition. Serum from another human being may be employed, but horse serum, already obtainable on the market ready for injection, serves well in many cases. One cannot lay down any absolute rules as to exact dosage or frequency of repetition of the dose, but in an average case 20 c.c. of sterile horse serum is given subcutaneously into the flank at a time when the patient is not suffering from active hæmophilic symptoms such as acute hæmorrhage into a joint. Little or no trouble results, and although there may be some hæmatoma formation at the site of inoculation, even this

complication does not necessarily occur, and there is no particular liability to serum phenomena such as urticaria or joint pains on the eighth or ninth day after the injection in the way that might have been expected. Even when the serum phenomena result they are but temporary; during the twenty-four hours immediately following an injection there is generally a transient rise of temperature, and the patient should be kept in bed until this has passed. How many hæmophilic patients are liable to become hypersensitive to the serum we do not know, but we have not met such a case, although the routine treatment has been to repeat the 20-c.c. dose of horse serum in a month's time and thereafter at monthly intervals for many doses. It is rather important to give the injections slowly if bruising is to be reduced to a minimum, but one does not know how many times the injections should be repeated altogether. It may be that it would be wise to go on monthly for two years and then to give an occasional dose at longer intervals, but even from a small number of doses there is often a great improvement in the patient's tendency to bleed from small scratches and abrasions, and in those patients who have hitherto been liable to hæmorrhagic effusions into the joints these complications may be entirely prevented from recurring.

If there is any fear of anaphylaxis and the phenomenon designated colloidoclastic shock, measures directed towards minimising any tendency to this can be adopted by mixing the serum with an equal volume of 5 per cent. solution of hyposulphite of soda.

6. Purpura Treated by Horse Serum Injections.

Purpura is not a disease but a symptom, resulting from the effects of many and various disease processes: some microbic toxins, *e.g.*, in septic states; some chemical, *e.g.*, from iodides; some due to errors of metabolism, *e.g.*, scurvy; and others perhaps to different groups of causes or combinations of them; so that when one speaks of the treatment of purpura one should really be speaking of the treatment of that condition causing the purpura in a particular case. There are, however, some cases in which the purpura occurs without known cause; and when this is so, there is a tendency to regard the purpura itself as the disease, though there must really be an underlying cause for the symptom, even though it is not discovered. There are probably many varieties of this type of case, and it does not imply that we understand the pathology of the condition any better when we give a definite name to it such as Henoch's purpura than when we give no special name to it, but designate the condition purpura simplex or purpura hæmorrhagica. If we knew more about the underlying pathology of this type of case we should be nearer to success in treating it; but it is known from actual experience that injections of exogenous serum given subcutaneously do lead to amelioration of the purpuric state in many cases of the kind, so that purpura may be added to the list of conditions in which exogenous protein therapy does good. Whether normal horse serum is the best to employ for the purpose we do not know; it is more than likely that sera from other animals or from human beings might do better still; but on the other hand there is equal possibility that these other sorts of sera might do harm instead of good. It has at any rate been discovered that the giving of 20 c.c. of normal horse serum into the deep subcutaneous tissues of the abdomen, flank, or elsewhere, is often followed by a diminution in the hæmorrhagic tendency exhibited by the patient, the way in which this occurs being comparable, one supposes, with the way in which hæmophilia is relieved, as just described.

Purpuric cases are much more acute as a rule than is hæmophilia, and it is impossible to lay down absolute rules as to when the serum should be repeated; but, generally speaking, in a moderately acute case of purpura one would give a second dose of 20 c.c. of normal horse serum on the second day, a third dose of the same size on the third day, and thereafter decide by the circumstances of each individual case whether to give further doses or not. Seeing that the phenomena of serum disease are apt to develop about the eighth day after an injection of horse serum, it would generally be wise to desist from giving further injections after the sixth day, and then the risks of anaphylaxis, and liability therefore to sudden death from colloidoclastic shock, are such that one would feel far from confident in giving further doses until a period of weeks had elapsed. Even then one would feel dubious about repeating the serum after so considerable a quantity had been given during the first week. Even a single dose, however,

often gives considerable relief to the purpura, and unless there are obvious contra-indications at the time, there is generally no reason why the dose should not be repeated daily for six days.

Milk Injections instead of Peptone or Serum.

Several observers, *e.g.*, Stracker,[10] advocate the use of intramuscular injections of sterilised milk in the treatment of patients suffering from chronic septic troubles—sinuses, discharging amputation stumps, and so forth; 10 c.c. being given at a time, and the dose repeated daily for many days. The data for judging whether this is a valuable line of treatment or not are as yet insufficient; but the fact that milk is being thus employed by some is mentioned here particularly because it shows that when speaking of foreign protein therapy in general one should not confine one's attention entirely to peptone solutions, nor to non-specific vaccines, nor to horse serum. It seems likely that various other foreign proteins may produce beneficial results in certain conditions when given by injection; but the time is not yet ripe for giving any precise summary of their value in actual practice.

Desensitisation to Food Idiosyncrasies.

The average person is able to eat all the ingredients of ordinary human mixed diet without suffering ill effects, if he eats them in proper quantities and in the right way. Some unfortunate individuals, however, find it impossible to eat certain things without the penality of subsequent urticaria or an acute abdominal upset or other evidence of personal idiosyncrasy and inability to deal with this particular food substance with impunity. Whether it is the actual foods which upset him, or whether on the other hand the individual, having ingested the particular foodstuff, produces within himself an antifood protein body to which he is too sensitive, is uncertain. Two very familiar examples of what I mean are strawberries and crab; the majority of people can eat strawberries without being ill, but some cannot eat even one strawberry without being upset and possibly developing severe urticaria; similarly in regard to crab. Now, although these two substances are familiar to everyone—lay and medical alike—in this respect, it is less generally recognised that some individuals are similarly upset by one or other of a great variety of other food substances which ought not to upset an ordinary human being. They have a food idiosyncrasy, and it is by no means necessarily imagination on their part. Though there are many who attribute their symptoms to some particular article of food without reason, there are definitely individuals who cannot take cow's milk without being ill; there are others who cannot eat eggs without being upset, and this even when the eggs are disguised so that the patients do not know they are eating them at all. Some cannot take a glass of champagne without coming out into blotches on their legs; and so on. In the process of growth it is probable that a child hitherto brought up on nothing but its mother's milk, but coming to the stage when change has to be made in the direction of other foods, has to get his internal chemistry readjusted to this change, and in the process of readjustment there may temporarily be quite considerable upsets; and yet as time goes on and the child continues with the primarily upsetting food, an immunity to it is, as it were, developed, and that which upsets at first does not do so later on. There seems little doubt, for example, that a change from mother's milk to cow's milk will upset some children very much indeed, but with continuance of the cow's milk dietary the upset ceases to recur. Some children when first put on to eggs develop severe gastro-intestinal disturbances in a similar way until they get used to this food. It would not be surprising if some individuals never develop the power of getting used to the ingestion of the foreign proteins that their interior has to learn to deal with, and when this is the case they have a continued idiosyncrasy.

Nor is it only to foods that this applies. We all inhale the pollen of grasses in the early summer. One does not know how to judge the effect of grass-pollens upon the child the very first time it inhales them, but most children develop an immunity to the pollen itself and the antipollen substances that their bodies produce when the pollen is thus taken in. A few never do so, and these are the sufferers from recurrent hay fever.

With these few examples in mind, it opens up a very wide field when one thinks how many different symptoms, not merely urticarial on the one hand, or gastro-intestinal on the other, or in the form of coryza on a third; but quite different symptoms such as recurrent

headaches, bilious attacks, possibly the cyclical vomiting of infants, perhaps even the phenomena of so-called congenital pyloric stenosis of babies, may be the result of idiosyncrasy to some substance, protein or otherwise, which is ingested by the individual in the ordinary course of eating and living.

The way in which attacks of true spasmodic asthma may be due to persistence of food or other idiosyncrasy in this way has been referred to earlier in this article, and when one realises how common it is to have a tendency to hay fever in the same individual as is the tendency to spasmodic asthma, one sees how, when there is already one idiosyncrasy, there is liability to another, owing perhaps to the peculiar chemistry of the individual.

It is also a remarkable thing that people with the idiosyncrasy which is in the form of spasmodic asthma, are also far more liable than is the average person to that troublesome form of idiosyncrasy which is known as serum anaphylaxis; that is to say, a tendency to die almost suddenly from a second injection of serum when a previous dose of serum has been given within the last few weeks. Much, very much, has still to be learned about the chemical phenomena underlying these food idiosyncrasies, these pollen idiosyncrasies, these serum idiosyncrasies; and the last few years have seen a considerable beginning of the investigations; so much so, indeed, that an elaborate series of skin tests has been devised in an attempt to ascertain whether a given individual is unduly susceptible to the effects of this, that, or the other foodstuff or foreign protein.

The whole subject is so fascinating that enthusiasm is already leading many to expect more from this type of research than can as yet be said to be of proved value; but it is only by knowing the methods that are being adopted that further work can be done with them. If it is thought that some food product, or some foreign substance such as grass-pollen or dog dandruff, may be responsible for particular disorders and symptoms in any individual patient, something can sometimes be learned in confirmation of this by testing the patient with dried extracts of all kinds of food products and other things that are now available for the purpose.

The procedure is more or less like that of doing multiple von Pirquet reactions, using, however, the dried extracts instead of the tuberculin which was used by von Pirquet. Dozens of tiny areas are scratched in regular sequence upon some surface of the body, such as the forearm, and into each successively is rubbed the product to which it is desired to test the sensitiveness of the patient.

Americans have been doing a great deal of work in this direction, and as an indication of the kind of extracts employed the following list of those at present available may be given; other substances will doubtless be added:—

FOOD PROTEINS FOR CUTANEOUS TESTS.

Almond	Fig	Pineapple
Asparagus	Ginger	Plum
Banana	Goatmeat	Pork
Barley	Goose	Potato
Bean	Grapefruit	Radish
Beef	Guinea-hen	Raspberry
Beet	Haddock	Rhubarb
Blackberry	Halibut	Rice
Bluefish	Herring	Rye
Brazil nut	Lactalbumin	Salmon
Buckwheat	Lamb	Scallops
Cabbage	Lentil	Shad
Cantaloupe	Lettuce	Smelts
Carrot	Lima bean	Sole
Casein	Lobster	Spinach
Cauliflower	Mackerel	Squab
Celery	Milk (breast)	Squash
Cheese	Milk (cow)	Strawberry
Chestnut	Milk (goat)	Sweet potato
Chicken	Mustard	Tea
Clam	Oat	Tomato
Cocoa	Onion	Turnip
Codfish	Orange	Turkey
Coffee	Oyster	Veal
Corn	Parsnip	Walnut (English)
Crab	Pea	Wheat(whole)
Cucumber	Peach	Wheat gliadin
Duck	Peanut	Wheat globulin
Egg-plant	Pear	Wheat glutenin
Egg-white	Pecan	Wheat proteose
Egg (whole)	Perch	Wheat leucosin
Egg-yolk	Pike	

Incidentals:—Beef serum, Horse serum, Tobacco, Mouse hair, Orris root, Mushroom.

EPIDERMAL PROTEINS FOR CUTANEOUS TESTS AND TREATMENT.

Cat hair	Dog hair	Rabbit hair
Cattle hair	Goose feathers	Sheep wool
Chicken feathers	Horse dander	

BACTERIAL PROTEINS FOR CUTANEOUS TESTS AND TREATMENT.

Staphylococcus pyogenes aureus	*Streptococcus viridans*	
Staphylococcus pyogenes albus	„	*hæmolyticus*
Staphylococcus pyogenes citreus	„	*non-hæmolyticus*

Micrococcus tetragenus	Pneumococcus, type 1
,, *catarrhalis*	,, ,, 2
Diptheroid	,, ,, 3
B. pertussis	Friedländer's bacillus
B. coli communis	

POLLEN PROTEINS FOR CUTANEOUS TESTS AND TREATMENT.

+ = Early spring. + + = Late spring and early summer. + + + = Late summer.

Gramineæ—	*Leguminosæ*—
Timothy + +	Alfalfa + + +
Red top + +	Clover (trifolium) + +
Orchard grass + +	Sweet Clover (melilotus) + +
June grass + +	*Salicaceæ*—
Corn + + +	Poplar +
Compositæ—	Willow +
Goldenrod + + +	*Miscellaneous*—
Fleabane + +	Rose + +
Ragweed (short) + + +	Birch +
Ragweed (giant) + + +	Elm +
Cocklebur + + +	Maple +
Goldenglow + + +	Oak +
Sunflower + + +	Pine +
Daisy + +	Privet + +
Dandelion + +	Walnut +
Dahlia + + +	Greasewood + +

If the patient gives a strong reaction at one of the inoculated spots it is regarded as evidence that he is unduly susceptible to this particular substance; if, for example, in a case of asthma the whole series of inoculations is carried out, and the patient's skin reacts negatively to everything except, we will say, egg-white and the extract of dog hair, this is regarded as indicating that in that patient's dietary egg-white should be excluded, and that there should be no dogs kept in the patient's vicinity, and so on.

It seems hardly likely that the matter can really be so simple as this, and it is far too early to give any definite opinion as to the value or otherwise of this line of investigation; but sufficient cases of definite and useful knowledge obtained from skin reactions in this way have been recorded to make one realise the possibilities of the thing being of still greater value in the future, when it has been tried more extensively, its pitfalls and imperfections have been discovered, and a good deal more has been learned than we know at present.

When, however, these skin reactions have led to the idea that a particular individual is unduly susceptible to a particular food or other foreign protein or chemical substance, it is asserted that much can be done to make him less sensitive to this thing by subsequently giving him, by injection subcutaneously or intravenously, tiny but increasing doses of the extract of the particular substance to which he has the idiosyncrasy. This method has been employed in the relief of some cases of asthma, for example; but if the future shows that many other maladies besides asthma are attributable to personal idiosyncrasy to some particular foreign substance, and if beyond this it is confirmed that the patient can be desensitised to the substance by receiving a course of inoculations prepared from it, there will be a very wide opening up of that field of treatment which has been designated foreign protein therapy.

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7. *Comptes rend. et Mém. Soc. de Biol.*, 1916, lxxix., p. 648.
8. *Ibid.*
9. *Presse méd.*, 1918, xxvi., p. 485.
10. *Surg. Gynecol. and Obst.*, 1921, Feb., p. 127.
11. *Policlinico* (sez. chir.), 1921, Feb., p. 50.
12. *Presse méd.*, 1921, March 5.

Pass List.

FINAL EXAMINATION FOR THE L.D.S. FEBRUARY, 1922.

Part I.

D. J. Baker.	R. Maxwell.
A. J. Britz.	R. H. Muller.
T. C. Butler.	H. S. Murray.
L. S. Campbell.	L. B. Osborne.
H. A. Clark.	M. Patlansky.
B. Crisp.	H. G. Ryder.
L. Evans.	E. Samuels.
T. F. Fox.	E. H. L. Sander.
F. C. Gardenner.	E. A. Shepperd.
L. G. Godden.	W. O. Sims.
G. W. Griffith.	C. H. Stevens.
F. H. Hayns.	W. H. Taylor.
J. B. Hine.	C. P. Urbain.
J. A. Hudson.	F. A. Walker.
E. M. D. Mackie.	C. B. Wilson.

Surgery.

J. S. Dick.	J. R. Palfrey.
R. Hofmeyer.	A. E. Tidd.

Anatomy and Physiology.

E. A. J. Bradley.	F. G. Hutchinson.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Rugby.

SIR,—The "Rugger" team having completed their programme, it is interesting to compare 1920—21 results with the past season's.

Although we have not scored so many points, and have had more points scored against us than the 1920—21 season, the record is a better one, and one to be proud of, when we remember that the past season's fixture list was much stronger, most of the leading English and Welsh teams having been met and in most cases beaten at least once. The following table shows 1920—21 and 1921—22 results at a glance:—

1920—21.—P. 27; W. 19, D. 2, L. 6; 600 Pts. for, 96 against—74·07%.

1921—22.—P. 35; W. 26, D. 2, L. 7; 467 Pts. for, 162 against—77·0%.

This is undoubtedly the finest "Rugger" season Guy's have had, for with the above record, we have to couple the fact that R. F. H. Duncan obtained three "caps" for England, and no less than three other forwards played in trial matches, and there is no doubt that if South Africans were included in the English team, Guy's would have had at least two more "caps."

Might I bring to your notice a suggestion that was made to me by an old "Rugger" captain of Guy's. Would it not be worthy of Guy's rugby record to have printed on the fixture card and programmes that are sold at H.O.P., the number of seasons the rugby club have been playing, 1922—23 is the 80th, if the record that states Guy's commenced in 1843 is correct, and I understand it is. It is interesting to know that if this is the case, Guy's are the oldest Rugby club in the country having a continued existence.

In closing, I think a word should be said about the good arrangements at H.O.P., when big matches are being played, and also what a great asset the new stand is.—I am, Yours, etc.,

R. CANVIN HOLLOWAY.

100, Elliscombe Road,
Old Charlton, S.E.7.
April, 1922.

The Labour Party's Pamphlet.

DEAR SIR,—The Labour Party very rightly demand for all a life worth living, with work under the best possible conditions, and now comes a fine statement of their desire to save unnecessary suffering and loss by suggested co-ordination of all existing medical systems.

The pamphlet has been accepted generally as well informed, but the short section dealing with "Nurses" appears to me to give an extremely erroneous impression and to be without knowledge of present day developments or recognition of the splendid material improvements all through the Profession.

I know only too well that we are only at the beginning, far from our ideal, but modern nursing is of recent growth, with a wonderful and also difficult tradition, including the claims of the conventual life and the modes and manners of the "Gamps" and "Prigs," our immediate predecessors! Present wrongs are not removed by quoting past abuses, but it may not occur to the nurses and men working in the Hospital to-day, how much time, thought and money have been expended to benefit mutually both the patients and the workers—say within the last 20 years.

In criticising some of the statements and omissions in the pamphlet I have that period of time in connection with Hospital life to draw upon, including four years as Probationer and Nurse, and seven years as Ward Sister. In the past, salaries were naturally ruled by supply and demand, as there were long waiting lists of would be Probationers at all the large Hospitals and Infirmaries and keen competition for all posts for the certificated women. Now salaries are on a higher level and a minimum and standard scale has been introduced, and at the moment the actuaries are working upon a general scheme of Superannuation for the whole profession —a long felt want.

There is no mention of the establishment of the General Nursing Council and all educational developments, with the published syllabus for uniform teaching and demonstrations in all Hospitals, and scholarships for intending teachers, or the State Register and State Examinations. I believe that until Sir Cooper Perry was Superintendent at Guy's there had been no recognised courses of lectures for the Nurses.

Next comes the complaint of complete subordination of the Nurse to the Matron, Sisters, and Senior Nurses, and of servility where the Doctors are concerned. Surely all civilisation rests upon an ordered condition of life, and our instinct to honour where honour is due has developed certain courtesies which take different forms in different walks of life. The nurse who opens the ward door for the House Officer honours not the man of the moment but the highest of all Arts, that of healing.

No woman can take up any trade or profession or mix with a large number of people without experiencing some disappointments, misunderstandings, or perchance, petty tyrannies, but I must say I met with very, very few cases of genuine unhappiness.

To most of the nurses the matron is a lifelong friend and adviser, and I am quite sure no post

is ever delivered at Guy's or other large Hospital which does not contain a letter to the Matron from a past nurse, maybe entailing an expenditure of time and sympathy in obtaining the writer congenial work, or getting a sick relative into Hospital —all of which is gladly undertaken, with a thousand other acts of kindness.

Sisters and Nurses are more than often real sources of inspiration to their juniors. My first Head Nurse, by her personal character and professional skill, set a high ideal before me and that the starting point was the immaculate condition of "Mary" bathroom, or "lunches round to time," appeared to me as part of a well ordered scheme, which made my work a pleasure and was certainly good for the polish of the bath!

I cannot accept the suggestion that the Hospital authorities do not consider as desirable the human individual touch with the patients, it is only by virtue of the possession of those qualities that they hold their onerous positions. It will be agreed that the routine work, for which brisk cheerfulness is a great asset, is governed by the number of nurses employed, and an addition to-day to that number is a serious economic problem.

Since the war staffs have everywhere been increased to give the longer "off" duty time and although many nurses may long to treat each patient as a "private patient" there *is*, of course, real sympathy and understanding under present conditions. I could give endless examples—two must suffice—a nurse who went every "half-day" to a country village to see the children of one of her patients who was seriously ill for a long period—An educated woman who could not afford to give an adequate donation for the operation and treatment of her daughter came every week to the Hospital to do ward sewing and mending for more than ten years. Two facts should be noted, one that at present the Voluntary Hospitals are better staffed than those under the State. Taking occupied beds, the day and night staffs in the London Medical School Hospitals average 1 to 3 beds, in London Infirmaries 1 to 7 beds.

If the patient's day begins early, the night begins early too—8 p.m.

An example of increase of staff which was a great boon was a night probationer in each Surgical Ward. Previously one was "between" say "Martha" and Lydia," spending alternate weeks in each ward, relieving the opposite Head Nurse for her midnight meal, and in that half hour putting the breakfast ready, and dressing gowns and basins round, and returning again from 7 to 8 a.m. That was "a crowded hour of glorious life," without doubt, and it is all for the good of the patients and nurses that it no longer exists.

May I close by again stressing the sympathy that does obtain between nurse and patient and the nurse and those in authority. As an ordinary observer I always found it.

To your Guy's correspondent I would say that it is unthinkable that a Nurse could ever be "servile" to her patient.

The office of Nurse only exists in virtue of the patient's need, which is great, and appeals for service.—Yours faithfully,

F. A. SHELDON.
Late Superintendent, Guy's Hospital Trained Nurses' Institution.

Athletic Sports.

DEAR SIR,—The entries for the Sports are extremely poor at the time of writing. It is very difficult to understand why this should be so with such a large number of students at the Hospital. I should like to point out to those who say that they stand no chance against our crack athletes, that there are numerous handicap events included in the programme. In these events everybody stands an equal chance of winning.

There must be a tremendous number of men who have come up from public schools since the last Sports Meetings. Surely some of them are runners or jumpers of some kind; but none of their names have appeared on the entry form yet. However, one lives in hope that they will come up to scratch and help to make the Meeting a great success by increasing the number of entries.

I hope that the fact that the Sports are on a Tuesday will not keep anybody away who would have come on Wednesday. The change of date was absolutely unavoidable, as the British Red Cross have suddenly arranged a big Hospital Flag Day on the Wednesday, and will require the services of all available students.—Yours faithfully,

S. V. STRONG.
Hon. Sec. Athletic Club.

May 10th, 1922.

Publications Received.

British Medical Journal, New Cambridge, Old Cambridge, The Stethoscope (Bristol), The Gong (Nottingham), King's College Hospital Gazette, The Isis, The Nursing Times, Abstracts of Bacteriology, New York State Journal of Medicine, The Antiseptic (India), St. Mary's Hospital Gazette, St. Bartholomew's Hospital Journal, The Prescriber, Medical Journal of South Africa, Magazine of the London (R.F.H.) School of Medicine for Women.

Vomiting in Children.

CLINICAL LECTURE BY DR H. C. CAMERON.

GENTLEMEN,—

The stomach of the infant is adapted for a particular task, the digestion of breast milk. After a feed of breast milk the presence of free hydrochloric acid can be demonstrated; with artificial feeding the tests usually fail. Breast feeding is natural feeding, substitute feeding, no matter how cleverly managed, is unnatural feeding. With breast feeding the stomach empties comparatively quickly, generally in about one and a half hours. When cow's milk is substituted, owing to the delay caused by the coagulation of the much denser casein clot, the time which elapses before complete emptying is much longer, three to three and a half hours. The whey with the carbohydrates leaves the stomach first and passes the pylorus even before the conclusion of the meal. The casein clot with the fats is retained much longer. The use of sodium citrate with the cow's milk shortens gastric digestion considerably because it lessens the density of the casein coagulum.

The infant's stomach is tubular in shape and vertical in position. The cardiac opening lies opposite the ninth dorsal vertebra, the pylorus lies, as a rule, in the mid line, though sometimes just to the right of it. The capacity of the average infant's stomach at different ages is even to-day a matter of uncertainty. Measurements taken by aspiration are uncertain because of the very rapid escape of fluid through the pylorus. Measurements taken after death are inaccurate because the muscular coats undergo contraction, and distension must be achieved by varying hydrostatic pressure. According to observations post-mortem by Holt the capacity at birth in an infant born at full time is one and a half ounces, at three months four and a half ounces, at six months six ounces, at one year nine ounces.

Because the infant relatively to the adult consumes amounts of food which are very large, the function of digestion is comparatively unstable, and symptoms of disturbance such as vomiting are of common occurrence and are evoked by comparatively trifling causes.

Simple Regurgitation. Possetting.—Simple regurgitation of food without symptoms characteristic of dyspepsia is not uncommonly met with, especially among breast fed infants. Without crying, pain or apparent discomfort, and without any forcible act of vomiting, the regurgitated milk appears in the mouth or upon lips and chin. Possetting babies are commonly of good size and weight and the fraction of the whole feed lost is usually small. The vomited milk is hardly altered and has little of the sour smell characteristic of the vomited matter in dyspepsia.

Treatment.—Possetting of this sort hardly requires treatment. At the most it may be taken as evidence that the child is receiving amounts of food which are filling the stomach to the limits of its capacity. It is a protective device by which the child regurgitates any amount which if retained might distend the stomach uncomfortably. It may be wise to shorten a little the period of nursing. A gradual passage from this symptomless regurgitation to the true vomiting of dyspepsia is not infrequently seen and is indicated by the increasing sourness of the vomited milk, and a lengthening of the interval since the meal, with evidence of gastric discomfort and pain. With infants fed artificially possetting is less common.

Vomiting with eructation of wind.—In infancy wind is for the most part due to aerophagy. From the first the efficiency of the infant's suction is very great. Nevertheless, in early infancy, and most obviously in the first weeks of life, the adaptation of the child's mouth to the nipple and its power of swallowing the milk unmixed with air is sometimes faulty. As a result the stomach becomes distended with "wind." Aerophagy of this sort is most apt to occur when the infant is too eager and excited, and when it mouths and bites at the nipple in its over anxiety. With the drowsy, quiet child the sucking reflex acts much more efficiently. Nasal obstruction in the child naturally adds to the difficulty, as does depression or malformation of the mother's nipples.

When the stomach becomes distended with wind, the child may refuse to suck further, showing obvious signs of discomfort. With regurgitation of the wind relief is clearly obtained. It is not infrequent to find that the eructation of the wind is accompanied by the vomiting of a great part of the stomach contents.

Treatment.—To prevent vomiting of this sort we must endeavour in the first place to put a stop to aerophagy. The child should not be fed when too excited or after crying. Handling by a skilled nurse who knows how to quiet the baby's nervous system is an important part of the treatment. Small doses of Chloral Hydrate, grs. 1 or 2, or of Potassium Bromide, grs. 1 or 2, three or four times a day given before meals and accompanied, if necessary, by a hot pack will often assist, if the unrest of the child has become really serious, in producing the necessary quiet for the important act of nursing. Depression of the nipples and nasal catarrh must receive the appropriate treatment. When in spite of every care the stomach has become distended with air, the instinct of the mother to hold the child upright and await the escape of air is correct. In this upright position the bubble of air in the cardiac part of the stomach comes to lie almost directly under the cardiac opening of the stomach, and can therefore, be expelled with comparatively little effort. If the child is laid down, on the other hand, the air bubble is apt to pass to the fundus and to the left, and since it thus becomes shut off from the cardiac opening, the air can only be expelled by a relatively great effort which is liable to dislodge the fluid contents of the stomach at the same time.

With artificial feeding aerophagy and consequent vomiting is not met with at all frequently. Suction from a bottle is comparatively effortless and unless the bottle is carelessly given there should be no admixture of its contents with air.

Vomiting with other signs of neurosis.—With some nervous infants we find vomiting as a constant symptom from the first. The severity of this habitual vomiting varies greatly in degree. In the worst cases its persistence and violent projectile character, as well as the considerable emaciation to which it gives rise, lead to confusion with the vomiting of hypertrophic pyloric stenosis, from which indeed it can only be distinguished by the presence in the latter of the greatly hypertrophied stomach and the palpable pyloric tumour. Nervous infants with habitual vomiting are usually thin, meagre, restless and rigid with increase of muscular tone, so that the position adopted is almost one of opisthotonos. There are no other dyspeptic symptoms such as abdominal distension, pyrexia or failure of appetite. As a rule vomiting of this sort ceases before the end of the first year, to be replaced perhaps by other manifestations of the nervous inheritance.

Treatment.—The vomiting may be most intractable, yet except for the increased risk of intercurrent infection, increased because of the prolonged flattening of the weight curve which accompanies the vomiting,—the tendency is always to complete recovery. It is important to recognise these cases and to distinguish them clearly from cases of primary dyspepsia, because their treatment is very different. Deprivation of food and partial starvation only serve to increase the vomiting and the nervous unrest on which the vomiting depends. In this it resembles the vomiting associated with anorexia nervosa in adult life. A comparatively generous diet is indicated in both conditions as the first step in treatment. The provision of a good infant's nurse is essential. Her quiet confident handling, replacing over-anxiety and fussiness, will diminish the nervous tension of the baby. The anxious look will leave its face, the limbs will become less rigid, sleep will become sounder, and the stomach will grow less intolerant.

Sodium citrate or sodium bicarbonate (grs. 30 per diem in each case) in this form of vomiting are often immediately successful. The tolerance for fat may be low and at times it may be necessary to lower the percentage of fat and to make a corresponding addition of sugar. Children who suffer from nervous vomiting of this sort during infancy are often the offspring of highly nervous parents whose over-anxiety makes the management of the case very difficult. In such cases we have especially to set our faces against excessive medication and too frequent dietetic changes.

Vomiting with hypertrophy of the pylorus.—We do not know the cause of the great overgrowth of the circular muscular fibres of the pyloric portion of the stomach, which produces the condition generally known as hypertrophic pyloric stenosis. The symptoms seldom begin until some time, very often about three weeks, from birth. Sometimes the symptoms seem to develop from and to be a further complication of that functional nervous inco-ordination of the stomach described under the preceding heading. Boys are much more often affected than girls, the first born more often than children born later in the family. A distinct nervous inherit-

ance is often found. The condition is comparatively rare in hospital practice. The majority of the cases occur in breast fed children.

The symptoms, taken with the physical signs, are characteristic. After a meal, which is generally greedily taken because of the hunger, the baby shows evident signs of discomfort. If the abdomen is examined at this time a ball-like swelling may be seen to rise in the left hypochondrium and to pass slowly from left to right across the epigastrium. Often two or three such peristaltic waves can be seen following each other. The pylorus can be felt as a hard tumour, about the size of the terminal phalanx of the thumb, lying in the middle line or just to the right of it. The enlarged pylorus can be felt to harden as the wave of peristalsis reaches it across the hypertrophied stomach. Between these waves there may be considerable intervals when it is difficult to palpate. Hypertrophy of the stomach, as shown by visible peristalsis and a palpable pylorus, may be developed with very great rapidity. Often they are present within a few days of the onset of the vomiting. Even in cases which are relatively mild, these striking signs should be present at the end of a fortnight or three weeks, and should serve to make the diagnosis clear. The vomiting is copious, explosive, and comparatively effortless. In a wide stream the contents are projected often for a foot or more from the child's mouth. The vomit is never bile-stained, as it always is in congenital atresia of the upper intestinal tract, a condition with which occasionally confusion may occur. Emaciation is progressive and is apt to reach an extreme degree. The stools are infrequent and scanty, dark, slimy, pigmented, and somewhat resembling meconium. As the obstruction yields, improvement in the character of the stools is one of the first signs of recovery. The urine is commonly scanty and high coloured.

The severity of the symptoms varies greatly in different cases. The duration, when no operation is performed, is often about ten weeks. Towards the close, weakness and emaciation may be extreme. It appears almost as if spontaneous recovery only took place when the general weakness has become so great that the spasm yields, just as the spasm in whooping cough diminishes as the strength fails.

Treatment.—In cases of considerable severity, and these are the more common, immediate surgical intervention offers the best hope of recovery. The pylorus may be stretched after opening the stomach, or without opening the stomach, an incision may be made through the hypertrophied pyloric musculature down to the mucous membrane (Rammstedt). Posterior gastro-enterostomy is an operation of greater severity, and although infants after gastro-enterostomy often thrive uninterruptedly and grow to vigorous and healthy childhood, nevertheless it introduces anatomical alterations which seem too permanent for a condition which is transient and yields spontaneously after a comparatively few weeks. Success, however, depends more upon the individual experience of the operator with the method adopted and upon the skill with which the after-care is managed than upon the particular method adopted to overcome the obstruction.

The mortality is very much greater in bottle fed infants than in those that are breast fed. In the last fourteen breast fed cases in which I have had a Rammstedt operation done, all have recovered.

When the general condition of the child is too feeble to permit of operation, or in very mild cases in which symptoms, not very severe, have been present for many weeks without causing great loss of weight, and which therefore may be regarded as being within reasonable distance of spontaneous recovery, medical treatment may be adopted. Most reliance must then be placed upon regular and daily lavage of the stomach, usually performed night and morning or even before each feed.

The breast-fed child should not be weaned, but if necessary the milk may be drawn off from the breast with a breast pump and given to the child with a spoon. In this way it may be retained when it is constantly vomited after suction at the nipple. The drawback is the danger of failure of the flow, consequent on removal of the stimulus of the child's suction. Sometimes the milk is better retained if given cold, after being set on ice.

Immediately after nursing five grains of sodium citrate may be given in water. Sometimes small and frequent feeds at intervals of one and a half or two hours are best retained, but there are many instances in which greater success follows the plan of adhering to the long four-hourly intervals, washing the stomach free of food residue before each meal. Extra fluid should be given per rectum, and

in pyloric stenosis the fluid given in this way is usually well retained, so that subcutaneous infusion is seldom necessary. Four to six ounces of normal saline or dextrose (grs. 105) dissolved in four ounces of water may be injected slowly by tube and funnel at six-hourly intervals. Warm fomentations to the abdomen relieve pain and sometimes seem to control the vomiting. If the baby is already being artificially fed, a mixture which is likely to pass through the pylorus as quickly as possible should be chosen. For this reason mixtures with a high percentage of casein and of fat must be avoided. Whey with added dextrimaltose (Mellin's Food) is often well borne, given in doses of one ounce at intervals of one or one and a half hours. When milk feeding is again introduced it should be citrated fully. Of drugs directed towards diminishing the spasm little is to be expected. Tincture of opium, atropine or belladonna, pushed far beyond doses which would usually be considered suitable are commonly without result. It goes without saying that great care should be taken to conserve the infant's heat during the long period of inanition.

Vomiting with Dyspepsia.—In infancy vomiting is a constant symptom of dyspepsia. It is then commonly accompanied by diarrhœa, with frequent explosive defæcation and the noisy passage of gas from the intestine. The stools are acid, watery, green, and contain lumpy curds of soap and of casein. The temperature is generally a little raised. The curve of the weight becomes flat or weight may be lost. The child is restless, fretful because of pain and sleepless. The skin loses colour, and becomes of a greyish pallor. The abdomen is often distended. The vomited matter has a sour smell due to the volatile fatty acids.

Dyspepsia of this nature is commonly due to overfeeding, or in cases of artificial feeding to the use of a mixture of unsuitable composition. When vomiting is very prominent in dyspepsia, the fault is usually to be found in an excess of fat. Excess of sugar, on the other hand, commonly leads to excess of intestinal fermentation with diarrhœa as the more prominent symptom. In feeding with cow's milk dense casein curds may be ejected, but this is not to be taken as implying that the casein curd has caused the attack. The casein curd is not responsible for the dyspepsia, although it determines the character of the vomited matter. In primary dyspepsia of the nature which we are now considering, due generally to excess of food or unsuitable food, the onset, as a rule, is insidious. In this it contrasts with the sudden onset, a bolt from the blue, in vomiting and dyspepsia which is symptomatic of pyrexia and acute infections whether intestinal or non-intestinal. As a rule in dyspepsia from unsuitable feeding there have been several days of fretfulness and disturbed sleep before the disturbance culminates in vomiting.

Treatment.—Treatment is to be begun in all cases by a temporary withdrawal of food, for twelve or twenty-four hours, to permit the stomach to become empty. For that space of time water or albumen water may be given freely, while care is taken to keep the child sufficiently warm. Thereafter feeding may be begun again gradually. A breast fed infant may be put to the breast for five minutes at the usual four-hourly intervals and gradually the time of nursing may be lengthened. If the child is artificially fed, the first feeds after the preliminary starvation must be of small bulk until it is clear that tolerance for food is re-established as shown by the cessation of vomiting, and diarrhœa and the improvement in colour and sleep. If vomiting recurs with the resumption of food, the stomach should be washed out with a weak solution of sodium bicarbonate, and the attempt to feed renewed. The amount and composition of the food on which the disturbance originated must be scrutinised carefully and if necessary reduced. Especially it may be necessary to curtail the fat.

At the same time it is unwise to make sweeping alterations at a single stroke of the whole character of the diet, as, for example, in replacing a diet of whole milk or dried milk by a malted milk. Changes in the character of a young infant's food should always be gradually introduced. Similarly increase in the amount should not be on too large a scale. An addition of 10 per cent. is reasonable. To add 50 per cent. at a stroke is unreasonable and, though often done, is a common cause of dyspepsia. With breast feeding the prescription of too frequent feeds at intervals of two or two and a half hours is the most common cause of dyspeptic vomiting. The routine use of a four-hourly interval is to be recommended.

With bottle feeding the symptoms are commonly produced by sudden and unnecessary additions to the amounts taken, and additions upon a dangerously large scale, because of impatience with a weight which remains stationary for a few weeks. The conditions of temperature prevailing at the time must also be taken into consideration in adjusting the amounts given. In times of great heat food must be restricted to meet the lesser demand consequent upon the diminished heat loss. Amounts which can be well tolerated under ordinary circumstances become sufficient to produce dyspepsia with vomiting during a heat wave. The treatment of dyspeptic vomiting by drugs gives disappointing results, but in severe cases alkali should be given freely, sodium bicarbonate or sodium citrate in doses of 20 or 30 grains daily. Small doses of grey powder or calomel, grs. $\frac{1}{8}$, may assist in elimination. Opium is out of place, because the diarrhœa and vomiting are protective reactions in the interest of the child.

Vomiting with pyrexia.—The most common cause of sudden vomiting in infancy is that which is symptomatic of acute infection and pyrexia. In adults the invasion of some acute infective process is commonly ushered in with a single attack of vomiting or shortlived gastro-intestinal disturbance. In infancy the dyspeptic symptoms may persist throughout the whole illness and dominate the clinical picture throughout. This sudden onset of dyspepsia *ex infectione* is characteristic, and may help to distinguish it from primary dyspepsia *ex alimentatione*. Further, in infection the pyrexia is usually higher and is not lowered by temporary withdrawal of food. Infections, such as nasal catarrh, otitis media, influenza or pyelitis, which may be difficult to detect in infancy, are apt to pass as primary disturbances of digestion.

In the treatment of vomiting symptomatic of infection stringent dietetic restrictions are out of place. It must be explained that the child is ill from an ascertained infective cause and that while this lasts there may be a constant tendency to reject all food, even the most suitable. The daily amount given from the breast or bottle should be somewhat less than in health, and the total intake of fluid should be made up by the addition of water. Weak china tea, diluted to the colour of pale sherry, given in a bottle, is a good diuretic and stimulant for infants with high pyrexia.

It is generally necessary to lower the fat percentage in artificial feeding during prolonged pyrexia and to substitute a proportionate addition of sugar, which is generally well born in fever. In severe cases peptonising the milk will often be found effective in controlling the vomiting. We must resist the constant demands to change the diet. It is especially deplorable when a pyrexial illness, which in the nature of things is likely to be transitory, is seized upon as an excuse for weaning. If an infant at the breast suffers not only from vomiting and pyrexia, but also from loss of appetite there is of course some risk that the breast milk will disappear. This should always be guarded against by the use when necessary of the breast pump after nursing.

Reviews.

Diseases of Women. By Ten Teachers. (Messrs. Edward Arnold and Co.) Price 30s. net.

Following upon the successful launching of a text-book on Midwifery some four years ago the same Ten Teachers essayed the more difficult task of sublimating their combined wisdom in the production of a volume on Diseases of Women. The more recent work now joins its companion volume in a second edition. It must be gratifying to the editors to find that the experiment of collective authorship has been justified. Equally popular with the student, the teacher and the practitioner, these two text-books have established themselves, on their merits, as the best expositions of the subjects with which they deal.

Little alteration has been made in the second edition for the excellent reason that little was necessary. It has been the object of the authors to compile more than a mere text-book for the examination candidate: Gynæcology is treated mainly from its clinical aspect, but the importance of pathological considerations is brought out by judicious emphasis on accepted theories with only such passing reference to less established hypotheses as should stimulate the reader's interest.

The difficult and much neglected subject of chronic ill-health in women from the psychological aspect receives special attention in an admirable chapter written with a sympathy and insight which is rare in medical text-books. We shall see many further editions of this publication.

A Treatise on Glaucoma. By Lieut.-Col. R. H. Elliot, I.M.S. (Oxford Medical Publications.) 30s.

This is a large and exhaustive treatise on the subject, and although not a book necessary, or even advisable for a student to wade through who is studying for some pass examination, yet, nevertheless, it is one which every ophthalmic surgeon will be wise to read and keep by him. It reflects great credit on Col. Elliot's industry, and the thanks of the profession are due to him for the trouble he has taken both in compiling it and bringing it up to date.

Not the least part of its value lies in the fact that it embodies the observations of a surgeon who has faced many difficulties himself, and has undertaken the care of a number of patients suffering from Glaucoma, his views being everywhere influenced by his own personal experiences.

The statements with which the book opens suggest that in spite of much thinking and research the subject still has many unsolved problems.

"The term 'Glaucoma' is not the title of any single disease. It is rather a convenient clinical label for a large group of pathologic conditions, the distinctive feature common to all of which is a rise in the intra-ocular pressure."

"The causes of these conditions are many and varied, the pathological findings are most diverse, and the difference in the symptoms presented is so extraordinary, that very careful study is required to detect the bond which serves to unite these very dissimilar manifestations of disease in a common category."

The author seems to come to much the same conclusion when he is describing the operative treatment, and after asserting that the earlier we perform sclerectomy in a case of glaucoma, the better is our prospect of success; he asks, "Why then do surgeons hesitate?" and his second answer, "The fear of a bad result," sums up the present position, that all is not yet reduced to a matter of mathematical certainty.

Col. Elliot takes exception to an ophthalmic surgeon's work being judged solely by its results. But are not the public right to hold that view? A patient comes to have his sight saved, not to risk losing it, and if he loses it as the result of an operation, he will certainly blame the surgeon, although, as Col. Elliot suggests he would have lost it inevitably; but time is the essence of this matter, and to lose one's sight a day or even an hour before it is inevitable, increases the misfortune.

I think the critics are right, and the judgment by results is the only one which can claim to be final. The difficulty is greatly enhanced by the attitude of some surgeons who either deliberately cultivate, *or more frequently allow themselves to* be flattered into, the position of posing as magicians, to whom failure is unknown, and whose knowledge and skill are so limitless that the patient need not have the risk he runs pointed out to him.

No surgeon should operate in glaucoma without taking the patient honestly into his confidence, as to the probable, and possible results, and the patient must share the responsibility and know the risks before he submits to what may be for him, a disappointment. Many of these difficulties would be lessened by a greater honesty towards the patients concerning a possible failure. Glaucoma always was, and remains a disease for which there is no certain cure, in spite of the fact that medical and surgical treatment has many successes to record, and the general outlook has greatly improved. Col. Elliot says little of those cases in which glaucoma has been diagnosed incorrectly. One has seen cases in which iridectomy has been done, and the patient treated for glaucoma in which years after no evidence of glaucoma can be found. It is always difficult to be sure, but the suspicion remains that operative treatment was undertaken on account of a mistaken diagnosis.

The book is excellent, well printed and illustrated, and although one may disagree with the writer, there is never any doubt about what he means, and what are his views.

Medical Ophthalmology. By R. Foster Moore. (Messrs. J. & A. Churchill.) 15s.

This is a very useful and interesting little book, giving in a handy and concise form a number of facts not usually found in standard text books on ophthalmology. The information contained in the book is culled, to a large extent, from articles and monographs published by different authors in a widely various literature, and is not, to any very great extent, the result of the author's own personal observation, but is nevertheless a useful compendium of medical facts. The number of books dealing exclusively with Medical Ophthalmology is not great and we may surely welcome another.

The up to date views on the Cortical representation of Vision; the pathology of Papillœdema; Retinal Hæmorrhages; Arterio Sclerotic changes visible in the eye; Renal and Diabetic retinitis; Syphilis affecting the eye, etc., are all clearly dealt with; I do not find, however, any reference to Mr. Bardsley's paper on the changes to be found in the Retina as evidence of Arterio Sclerosis, and this is a pity as Mr. Bardsley's conclusions were very clearly and sincerely described.

Some of the accounts dealing with various forms of blindness, snow, eclipse, electric, etc., are very sketchy and incomplete, suggesting that the author

was tired of describing symptoms of diseases of which he had no personal knowledge, but was relating second-hand. By far the best chapters are those dealing with Renal Retinitis and Arterio Sclerotic changes. The length of the index compared with the size of the book suggests that it is very complete. There is further an index of Authors, and the printing, illustrations, and general arrangement of the book are excellent.

It is a book which may confidently be recommended to men working in the Medical Wards.

The Midwife at her First Private Case. By Margaret Robertson, C.M.B., Guy's Hospital, City of London Maternity Hospital, General Infirmary, Stafford. (Scientific Press Ltd.)

This is a useful little handbook for nurses. The title is rather misleading as the instructions contained in it are for nurses working under a doctor rather than for midwives conducting cases on their own. Miss Robertson sometimes goes into the most minute details, and on other occasions leaves much to the intelligence of the nurse, as when she says, on page 4, under the heading of "Sterile Water," "Leave it to become cold, when it may be poured into a bedroom ewer and covered over, until labour begins." Nothing is said about the preliminary sterilisation of the ewer, and that fresh water should be boiled each day. Also it is to be hoped she does not mean what one might infer from her statement on page 12, that everything can be put ready for the night, while baby is being nursed, such as milk, biscuits, bell, and within reach some clean pads. She surely cannot expect the patient to change her own pads, as if so what about the necessary swabbing?

The paragraph on sterilising will be one of the most helpful, although it is now possible to get the whole of the outfit ready sterilised in sealed tins at very little extra expense.

One other little criticism, and that is one of an omission. The nurse should endeavour to see the doctor as soon as possible after arriving at the patient's house, in case he should have any special instructions. I am sure Miss Robertson will agree to that.

Internal Secretions and the Ductless Glands. By Swale Vincent, LL.D., D.Sc., M.D., F.R.S. Edin. (Messrs. Arnold & Co.) Second edition.

The student of "Internal Secretions" is frequently appalled at the chaotic state of the subject of his study: in this work the author has valiantly endeavoured to bring order out of chaos, he has striven to separate the wheat from the tares and he has succeeded in producing a volume which gives a very complete resumé of the present state of our knowledge.

In view of the enormous number of experimental and clinical observations which have been made, the author is to be congratulated on his concise arrangement of data. Certain of the internal secretions, viz., those of stomach, intestine and kidneys, have been dealt with in a somewhat condensed manner, but the chapters on thyroid, pituitary and adrenal are very full, and the matter is clearly and lucidly put. The chapter on "Inter-relationships," is particularly welcome in view of the present-day theories which are so fashionable.

The claims of poor experiments, unsupported theories and unwarranted optimism receive their just criticism, and the author has rigorously maintained the attitude of "reasoned scepticism" which he believes to be so necessary to the establishment of sound knowledge.

Both the physiological and the clinical aspects of the subject are dealt with. The reader will be astonished at the enormous amount of material which the author has collected in such a small space—he, the reader, will not receive a simple and apparently complete story of the working of internal secretions: rather he will be furnished with a review of present-day situation and with ideas for the future advancement of that study.

Principles of Electrotherapy. By W. J. Turrell, M.A., M.D., D.M.R.E. (Oxford Medical Publications.) 12s. 6d. net.

The majority of books on electrotherapy appear to us to suffer from two drawbacks. Firstly, the author does not draw sufficiently on his own personal experience and secondly, the diagrams of instruments are provided by the makers and have their names attached. Dr. Turrell's book is free from these faults. The illustrations are excellent and most are original; while from a clinical point of view the book is, on the whole, excellent. We are, therefore, much surprised to read his remarks on the curability of ringworm of the scalp by means of Ung. Hydrarg. Ammon. and think that in the next edition he would be wise to include an account of its treatment by means of X-ray. The account of the Erlangen method of X-ray treatment is excellent though no opinion is expressed as to the results. We are inclined to think that it is not unattended with danger and a comparison of this treatment with long applications of radium would be of great interest. We should like to have had a fuller account of the action of diathermy both from a medical and surgical point of view, but in view of the moderate price of the book the space at Dr.

Turrell's disposal is obviously limited. Of its kind it marks a distinct advance on any other book we have seen on the subject.

History of Electrotherapy and Diagnosis. By Hector A. Colwell, M.B., L.R.C.P., M.R.C.S., D.P.H. (Messrs. Heinemann.) 17s. 6d. net.

Anyone who thinks that the history of medical electricity must be dull will change his mind on reading this book. It is, of course, closely connected with the history of quacks for few have neglected this form of treatment. But the interest of the subject is far wider. As an instance, we would refer to the reproduction of the cartoon in "Punch," of January 25th, 1896, of John Bull and the Kaiser, called "The New Photographic Discovery" which, "Thanks to the discovery of Professor Röntgen, the German Emperor will now be able to obtain an exact photograph of a 'Backbone' of unsuspected size and strength." Of particular interest to all Guy's men is the article on the Revival of Electrical Treatment at Guy's Hospital, where Golding-Bird, Addison and Gull, are specially mentioned and reference is made to Wilks' case of plumbism treated by the electric bath in 1872. This is the treatment now so strongly recommended by Sir Thomas Oliver for industrial lead poisoning. The book is full of interesting facts, of which these are merely examples. There are over a hundred illustrations derived from all sorts of sources,and Dr. Colwell is to be congratulated on the very readable book he has written.

The Medical Annual. Fortieth Year, 1922. (Messrs. John Wright & Sons, Ltd., Bristol.)

It is always of interest for a young man to meet an older of the same profession and to hear of the changes that have taken place since the start of his career. In the medical world above all others there is continual change. What were once regarded as epoch making discoveries are now common everyday occurrences.

It is with great pleasure that one reads in the recent volume of the Medical Annual the excellent survey of the work done during the past year. The greater part of the volume consists of a dictionary of practical medicine. This again consists, in reality, of reviews, by many well known contributors, on the year's work in the treatment of disease. In addition there are many original articles by eminent physicians and surgeons, putting forth the latest views and information on the subjects under discussion.

These subjects are arranged in alphabetical order, being accompanied in many cases by extremely good illustrations. We note with pleasure the incorporation, into the main body of the work, of articles hitherto included under Materia Medica and Therapeutics. A bad fault of many dictionaries is a failure to place some articles in the body of the work where one naturally expects to find them.

Whatever branch of medicine one may follow, it is of the greatest importance to keep in touch with the work of other departments, for each may cast light upon the other. We can thus sincerely recommend this volume to all those, both practitioners and students, who desire to keep in touch with the latest advances in all the branches of medicine.

Appended to the dictionary are numerous lists of new inventions, books, mental institutions, and directories, etc., which should prove of the greatest benefit to all practitioners.

Tumours, Innocent and Malignant. By Sir John Bland-Sutton, LL.D., F.R.C.S. Seventh Edition. (Messrs. Cassell & Co., London, New York, Toronto and Melbourne. 1922.) Price 30s. net.

A new edition of Bland-Sutton's "Tumours" should need no introduction to the multitude amongst whom the earlier editions have proved so popular. This, the seventh edition, retains the great fascination and interest, so commonly lacking from a large majority of text books, which were present in the earlier editions.

It is of interest to those Guy's men, who have followed the views of Dr. G. W. Nicholson, that the chapter on endotheliomas has been omitted, its contents being now dealt with elsewhere, and that even the term "endothelioma" is now being abandoned.

Many new facts have recently been discovered which tend to show the relation between some of the ductless glands and tumour formation. Whilst incorporating these, and other similar matters into the new edition, the author has ably succeeded in keeping the size of the book within convenient limits. There are sixteen pages more than in the previous edition, and changes have been made in twenty of the excellent illustrations, but in spite of these the size and character of the book have not suffered any considerable alteration.

Aids to Forensic Medicine and Toxicology. By W. G. Aitchison Robertson, M.D., D.Sc., F.R.C.P.E. Ninth Edition. (Messrs. Baillière, Tindall and Cox, London.) Price 3s. 6d. net.

Forensic Medicine and Toxicology seem to be the two branches of medicine which are most neglected by the average student. Reliance, during the short time before an examination, is placed, gener-

ally, in the Aids to Forensic Medicine! It is for this reason that we welcome a new edition of this extremely useful book. The opportunity has been taken of thoroughly revising and bringing it up to date in all respects. After the reading of one of the larger text-books it should be of great help to the student who is revising for his examination. But we have no doubt that, in many cases, owing to its excellent clarity and conciseness, it will entirely take the place of the larger books.

A Manual of Fevers. By Claude B. Ker, M.D., F.R.C.P. Second Edition. (Messrs. Henry Frowde, and Hodder and Stoughton, London.) (Oxford Medical Publications.) Price 12s. 6d. net.

The second edition of this popular book should do much to increase the esteem and merit acquired by the earlier edition. One might, in view of the recent epidemics, have expected extra chapters on influenza, poliomyelitis, and encephalitis lethargica. But we would rather commend the author on achieving his object of keeping the size of the volume within reasonable limits.

As a manual, to be read by students during their course of fevers, the book has a well deserved reputation. An excellent feature is the division of each subject into headings, thus tending to increase the reader's interest. The first two chapters include a general survey of all fevers with particularly good explanations as to the examinations of rashes and throats. The descriptions of each separate fever in the remaining chapters are well arranged as regards ætiology, diagnosis, prognosis, etc., so as to sustain the interest of the reader.

We can readily urge those students who are starting on their fever course to purchase this book which will prove an invaluable supplement to their clinical work.

A Synopsis of Medicine. By H. L. Tidy, M.A., M.D., B.Ch.Oxon., F.R.C.P.Lond. Second Edition Revised. (Messrs. John Wright and Sons, Ltd.) Price 21s.

The second edition of this valuable work differs but little from its predecessor, the rapid exhaustion of the earlier edition necessitating the publication of a second edition at short notice.

The section on Encephalitis Lethargica has been entirely re-written, and a few errors corrected. The general arrangement adopted resembles that of Osler's "Medicine," and the condensed information is so printed and arranged as to make it easy of access.

It must be borne in mind that this work does not pretent to be a text-book of medicine, and must in no way be allowed to replace one of the ordinary text-books. Its chief value is as a work of revision. When the student has read up his medicine in a larger text-book, and wishes to revise before his examination—then is the time when this volume is of incalculable service to the harassed examinee.

The author is to be congratulated on the production of a work which thoroughly deserves the success with which it has met.

Notices.

Golding-Bird Gold Medal and Scholarship for Bacteriology.

Mr. L. Forman. Medal and Scholarship.
Mr. E. H. Richards. Certificate.
Mr. J. H. M. Lloyd. Certificate.

Michael Harris Prize for Anatomy.

Mr. Ivor P. Spurrell. Prize £10.
Mr. D. W. C. Northfield. Certificate.

Wooldridge Memorial Prize for Physiology.

Mr. W. F. Roper. Prize £10.
Mr. D. W. C. Northfield. Certificate.

Junior Prizes for General Proficiency.

Mr. Ivor P. Spurrell. 1st Prize £20.
Mr. D. W. C. Northfield. 2nd Prize £15.
Mr. W. F. Roper. 3rd Prize £10.
Mr. H. J. Selby. Certificate.

Guy's Hospital Dental School.

Prize for Operative Dental Surgery. March, 1922.

Mr. K. G. Sharvill. Prize £10.
Mr. G. Beamish. Certificate.
Mr. O. H. M. Woolbridge. Certificate.

Maudsley Lecture.

Sir Maurice Craig will deliver the third Maudsley Lecture on Thursday, the 25th May, at 3 p.m., at the London County Council Hall, Spring Gardens, S.W. The subject with which he proposes to deal is: "Some Aspects of Education in Relation to Mental Disorder."

Charles Murchison Scholarship in Clinical Medicine.

The next Examination for this Scholarship will be held at the Royal College of Physicians of London, on Monday, the 12th day of June, 1922, and following days.

The Examination is open to any Student of Medicine, whether holding a Medical qualification or not, who, subsequently to the date of passing his professional Examination in Anatomy and Physiology for a Medical qualification, has studied for a period of not less than two and a half, and not more than five, years at a Medical School in London, recognised by the Royal College of Physicians, or at the University of Edinburgh, including Medical Classes recognised by the Medical Faculty of the University.

The Examination will be conducted both orally and in writing, and will include:—

(a) The Examination of Patients, with reports on their cases.

(b) Questions on Pathology and Treatment, and

(c) Examination on Specimens.

The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than May 29th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools, and evidence of the date at which they passed their examinations in Anatomy and Physiology.

(The Examination for 1923 will be held in the University of Edinburgh.)

J. A. ORMEROD, M.D.,
Registrar.

Pall Mall East, S.W.1.
January, 1922.

Specialities.

Messrs. W. and G. Foyle, Ltd., have re-arranged and improved their Department devoted to Second-hand and New Books on Medical, Surgical, Dental and Nursing Subjects. The requirements of the student, the practitioner, the specialist and the nurse are fully met, and Guy's men are invited to call and browse round the thousands of carefully classified volumes at their leisure, or to write for a Catalogue mentioning requirements. In either case they will receive every attention from the manager of the department.

When the "Gazette" was Young.

(*Continued*).

A Puzzled Ward Clerk.

Whilst on the subject of liniments and dermatitis, I remember that when I was holding my first appointment at Guy's as "Surgical Ward Clerk," a man was admitted into Accident Ward with an injured arm. To my horror, on examining him, I felt sure he was also beginning with small-pox. I remembered well the description the text books gave of the vesicles, and here they were in all stages; some small and globular, others large angry and deeply umbilicated. The more I examined them the more I felt sure of my diagnosis. Yet the whole of the man's sufferings seemed to be from the pain of the accident. I could not understand it. In the Colonnade I met old Mr. Stocker, the genial, kind, fatherly old man, always so ready to help a man fresh to the hospital. I asked him to come and look at it, telling him of my doubts. He looked at the eruption and said to the man, "Have you been using any liniment to rub your shoulder and chest with?" "O, yes, sir," the man replied. "I have and rubbed it in well!" Mr. Stocker turned to me and said quietly, "He has been using Croton Oil liniment. It always produces a rash like this." Dear old Stocker, there are, or were, many tales of him, *quæ nunc describere longum est.* His bent and venerable figure seemed a part of the very hospital itself. He was a link between the period which brought forth the Gazette, and the far off past which echoed with the sound and names of Cooper, Key, Bright, and others, immortal in the history of Medicine and Surgery.

Monson Hills.

Another familiar figure was the well-known and rotund proportions of Monson Hills, who outlived his functions. He was originally the functionary who presided over all the wet and dry cupping that was prescribed in the wards. His time then was not idle, it was well occupied, but when blood letting ceased, he took charge of the instruments, apparatus, splints and the rest of the thousand and one details of the operating theatre. He attended all

operations in the theatre, having charge of the ligatures sutures and needles. I can see him now, as the stands with eye-glasses on nose, head always on one side, twirling a ligature or suture in his grimy, unwashed fingers, holding it ready to transfer thereby his own personal species of germ, bacteria, etc., to the raw surfaces just then being prepared for their cultivation by the surgeon and his dressers. Hands then were never washed before an operation, but afterwards. An old thin overcoat was generally worn during an operation, and the more it was bespattered with old, dry patches of blood, and streaks of pus, so the more did it witness to the practical experience of the surgeon and his prolonged life and industry as an operator. What wonder that epidemics of "erysipelas" in the wards, and "puerperal fever" in the lying-in room of private houses were frequent and terrible in those days. These diseases were certainly recognised as "catching," even then, but it was considered more of an air conveyance than a direct implantation of the malady itself in the tissues. A request to define the difference between "contagion" and "infection" was a favourite *viva voce* question.

Certain diseases were said to be infectious, but not contagious; others were contagious, but not infectious. Typhus and other fevers were infectious only, but such local lesions as gonorrhœa were contagious only. The identity of principle, but divergence in method, was never for a moment considered.

A Monster.

About a year before the birth of the Gazette there was an event in parturition which excited much wonder for a short time, but which I do not think has been put on permanent record. These were the facts. An excited and agitated woman had come to fetch an extern to a "partus" case. She was in the Colonnade gesticulating wildly. Both the Charity were out and no "extern" or "casual" could be found. On the gate porter promising to send the first extern he could find, I went off with the woman. I soon saw it was a case for active interference, and sent word for the Charity to come as soon as possible, prepared for operation. After a time they came and succeeded, with great difficulty, in extracting instrumentally a huge dead fœtus. The parents refused to have it weighed, as it was "unlucky," but a baker guessed its weight empirically to be about 15 lbs. I measured its length as it lay on a flat surface; it was 21 inches. I have seen very large and fat infants, but none that ever approached this either in length or weight. It was not very fat, but of immense size. She said that all her confinements had been similar. How, or why, she was allowed to go on to full time, is more than I could say. She was a short, stoutly-built woman.

An Abdominal "Tumour"?

Some years after this another distinct yet similar question presented itself. It was Sunday; I was dresser for the week. I was called into the Surgery to see a woman who had a very prominent abdomen. She evidently was not of a communicative disposition, but briefly drew my attention to her abdomen. "You are in the family way, I suppose," I said. "How far are you gone?" "I am not in the family way," she replied. She made no further remark, but, at my bidding, took off her skirts for me to examine her abdomen. As she undressed, it seemed to me very likely that I should find her to be suffering from a large ovarian cyst.

The silence of the woman did not then strike me as remarkable. It was evident on palpation and percussion, that the whole bulk of the globular mass was due to a cyst, and, judging from its regular and even outline, was probably unilocular. It occupied the greater part of the abdomen, and was about the size of pregnancy at full term.

She said, in answer to a question, that she had not recently emptied her bladder. So, before proceeding futher, I passed a catheter and drew off the urine. The Surgery pôt de chambre of those days was about half the capacity of the utensil one generally sees. This was quickly filled, also again and again. I think I drew off thirteen of these pots-full before the catheter ceased running. The large tin bucket, which stood as a receiver for all slops and soiled dressings, was full, and the woman's abdomen was flat. The whole of the swelling was due to a distended bladder. She was very loth to give any history of the gradual development of such a remarkable tolerance of distension, but I was of opinion that it was of slow and gradual increase. I could find no cause for it, nor was there any urethral or other obstruction. I begged of her to come up daily

for treatment, as she said she was quite unable to micturate voluntarily and that it was the previous Sunday when she had it last attended to. I neither saw nor heard anything more of her until the following Sunday, when she again presented herself for treatment. She said that she had not passed any urine since I drew it off seven days ago, nor had she attended at the Surgery. She rejected all offers of treatment, save this one weekly attendance, as it was "no inconvenience" to her, and she did not object to it on the grounds of size or appearance. As far as this memoir is concerned, that was the end of the case. She was a remarkably taciturn woman, making no remark except in answer to questions.

Question of Psychology.

I have during the intervening fifty years seen an instance which had some points in common with this case, not in exact detail, but in some essentials. But the latter I had under close observation. I was not the medical attendant of the family, but was called in sufficiently frequently to enable me to get a fair grasp of the *deus ex machina*. Both were apparently healthy, active women in the prime of life. Neither presented those emotional, uncontrollable nerve storms which we vaguely call "hysteria," and both were entirely free from any anatomical fact which would account for their malady. But gradually and slowly it was forced upon me that the real cause lay in the brain of the latter case, and, though distinctly not hysterical, was due to one of those latent and obscure forms of insanity which at first are so difficult to detect. Would it be reasonable to speak of insanity of the motor area or tract? I think James Hinton, to us the aural surgeon, but to others the profound metaphysician, would have been able to show its possibility. So that when I look back with the light of subsequent experience, and note the sullen silence of the former woman with her refusal of all treatment, her insensibility to appearance, and toleration of such an extreme dilatation, as I have never seen, even nearly, approached, I doubt not but that a longer knowledge and more complete examination would have, in time, revealed central mischief slowly and insidiously commencing.

Latent Maladies.

Sir William Gull used to impress on the students the necessity of bearing in mind three obscure diseases which were very apt to escape attention and diagnosis—scabies, syphilis, and tubercle. I would add a fourth—latent insanity. A close investigation will show that a very large proportion of families have a trace of insanity in their medical history, which, like genius, will crop up now and then in quite extraordinary ways—colour blindness, tone deafness, lying, petty theft, and a host of minor manifestations, with here and there a case of petit mal, which under strain of hard brain work or brain fag, loss of sleep, or dissipation, will develop into "grand mal," or even delusions.

So never forget, in all obscure diseases, to pass in review cancer, tubercle, syphilis, latent insanity, and scabies. The latter is often overlooked in well-to-do people of the better class.

The Faculty of Observation.

This reminds me of an amusing incident in '73. I was up for the clinical part of my College of Physicians Examination at the London Hospital. My examiner was one of the physicians to that hospital. The first bed he took me to, contained a small, quiet-looking man, apparently not in much pain, of about 50 years of age. "Let me see what you make of this case," he said, as he made himself comfortable at the bedside, in an armchair. From the way in which he arranged his coat-tails, fixed the cushions and folded his hands, it seemed to me that he expected rather a prolonged "session." I approached the man and asked him if he had any pain. "No, sir." "Have you anything that causes you any suffering, such as shortness of breath, difficulty in breathing, loss of power, paralysis, or any of those other aches and pains that people suffer from?" "No, sir." "Are you losing flesh?" "Yes, sir." "Your skin is very dry and branny, is it generally so?" "Yes, sir." "Are you very thirsty?" "Yes, sir." I turned to my mentor, who sat in his chair looking rather surprised, and said, "Subject to further examination and analysis of urine, I should say he had got diabetes." "Quite so, quite so, but what made you think of that?" This staggered me, but after a moment's delay, I managed to satisfy my love of truth by replying, "General appearances, the whole entourage is suggestive of diabetes. The absence of any suffering, pain, or cough, etc.. his dry mouth and skin, his thirst and other general signs." "Quite so, quite so," he said,

and passed on in silence to another bed. To be candid, as we approached the bed, I observed a galaxy of urinary vessels, hidden under the bed, but not so closely as to prevent me detecting them, one or more of which contained a quantity of clear pale urine. I made no sign, and asked sufficient questions to allay all suspicion, but yet enough to clear the ground, as it were, for my conclusions, being careful not to make any reference to the "quantity" of urine he passed, lest I might, in turn, be asked if I had seen the collection under the bed.

I felt I had satisfied the truth in saying "general appearances," for we are often able to form a correct opinion by a casual glance or glimpse of some apparently outside object or occurrence. So in this case I did nothing underhand, but felt quite justified in using all the means in my power, which could in any way help me in forming an opinion.

Syphilis.

Perhaps the most frequent disease to escape detection is syphilis. Many reasons contribute to this: The disinclination of the patient to allude to his ever having had such a disease; the belief that he is cured when he is not; the inadequacy of the treatment generally adopted by *some* of the members of the profession, such as insufficiency of period of treatment, insufficient dosage, wrong use of wrong drugs (Pot. Iod., for example, in three-grain doses!); Pot. Iod. will never cure syphilis, even if taken for a life-time. It will often absorb masses of infiltration, but not in three-grain doses. One or more of these reasons coupled with the assurance of the medico that he is cured, has lulled many a one into a fool's paradise.

It is a good plan, and one often attended by most surprising results, to satisfy ourselves in the case of every fresh patient that comes up, that he or she is not suffering from this frightful disease, either acquired locally in his own lifetime or transmitted to him by his forbears.

It is never safe to trust to a non-professional man saying he has not had it. The chancre is often small and inconspicuous, often never noticed, sometimes disguised by a local ulcer or so-called whitlow, or any other apparently innocent and common eruption. There is never more than one chancre. It is always single.

Many years ago an eminent surgeon, named Budd, amputated the chancre and all the skin around it, hoping thus to eradicate the poison and prevent "secondaries." It was never successful, but proved that the hardening of the base was in itself not a *local* sign only, but the first indication of constitutional infection, being, therefore, itself the first secondary symptom. The terms primary, secondary, and tertiary are entirely conventional. There is no interval or change in process. Primary means the first inoculation; secondaries, the appearance of the disease in other parts; tertiary, the destruction of tissues and organs. We were first taught that syphilis was *never* curable. Then Ricord showed it was, in the primary and secondary stages, but not in the tertiary. Syphilis is curable in the primary and secondary stages, because there is nothing, as yet, destroyed. If the disease is removed, the body is left as before. The "tertiary" means that structure has perished, function lost, so that even if the disease could be eradicated, the ruined structures and organs can only be replaced by fibrous tissue. One will often see scars, post-mortem, showing that even in the tertiary stages, if taken early, it is just as curable as any other time. It is a question of how much can be saved and how much is lost.

A Healed Surgical Kidney.

In one of the early numbers of the Gazette, 1872, I think, a case is reported which was most instructive on these points. It was a case of stricture of the urethra in Naaman Ward under Mr. Durham. We were going to point to the lessons to be learnt from this case, but at the last moment Dr. Goodhart, who made the post-mortem, asked us not to say anything on the subject of the scars in the renal tissue, as it was his intention to write a paper for the "Reports" on the subject. Nothing, however came of it, so the unfortunate Gazette lost an interesting article without compensation.

What is Syphilis?

I can never but think that, under the name of syphilis, more than one, perhaps many distinct diseases, are included. Compare typhus, typhoid, paratyphoid, elephantiasis, lepra and other diseases, which originally were not recognised or distinguished, but had to be unravelled, as it were, from each other.

(Elliot & Fry, Ltd.)

DR. PATRICK P. LAIDLAW.

No thoughtful man can watch year after year, through a long life, an almost infinite variety without feeling that there is need of something other than marasmus or asthenia to account for the great variety of its methods of attacking the tissues, in its sequelæ, and the sometimes mild and sometimes severe onslaught. It is now the nerve centres, now the bones, and again the organs themselves, such as the eye, that are attacked. Why this distinction? Why should one have locomotor ataxy and another ocular trouble, and nothing else? The ultimate ramification of other definite diseases are more definite in course, why should not syphilis be? Why should the Wassermann reaction be so uncertain and unreliable when negative, if all cases were identical? It is, to my thinking, compatible only with one explanation, and that is, we are dealing with a group of diseases similar in many points, but distinct in others.

Dr. Moxon.

The late Dr. Moxon was very fond of dealing with questions of this kind, of pursuing a train of ideas until he felt himself landed in a difficult position, a sort of logical dilemma where apparently a paradox stopped the way. A knotty point, or a tangled mass of facts, he delighted to unravel. He had an acute sense of the ridiculous or incompatible, and would sometimes be very keen in seeing an identity in what was totally different. Though this is said to be the basis of all wit, it is easily degraded into a common lifeless pun. A pun without wit is like a dead thing that has once been alive, and Moxon was free from this. I remember once in church, the preacher, who was dealing with the miraculous draught of fishes, thought well to quote a passage from the works of Scott, the Commentator. Moxon turned round to me in a moment and said, in a low voice, "Too bad to give us common 'taturs with miraculous fish." This is not what I have called a "dead pun," it is the presentation, side by side, of two distinct opposites, in such a contrasted position, that from one point of view they blended and were harmonious, but from the other they were radically dissimilar. He was very fond of the students, and would often invite one or more to spend the week end with him at his house at Hornsey. He had a kind heart. I remember, shortly before the birth of the Gazette, he was asked to see an Extern who had broken down under the strain of heavy work. Moxon said he must be got home to his friends at once, and he there and then drove the patient up to King's Cross in his own carriage and insisted on one of his friends going with him. It was a long journey up north and required more available cash than the two could raise. He took them both first class tickets and put his hand in his pocket and drew out a handful of silver, and, without counting it, gave it to them for expenses on the way. He often enquired of us how the patient was getting on, for he had never been thanked for his pains and generosity, but we were in a like position, we were left quite out in the cold. I have reason for thinking that this "thoughtlessness" caused Moxon much uneasiness, but he made no comment.

To properly understand his writings it was necessary to know something of his methods. The short articles in the very early numbers of the Gazette, signed Pilocereus Senilis, were from his pen, though his locks at that time were a brilliant red. I never saw anyone's whiskers so devoid of curl. What "wave" there was, I think was artificial. He delivered the Introductory Address in 1867. It was truly, Moxonian, more so than anything he has written, and well worth reading to-day. He succeeded Dr. Wilks as demonstrator of Pathology. The Manual of Wilks on Morbid Anatomy, was a great favourite, but it got out of print, so Moxon re-edited it. It hardly met with the success that a simple re-printing would have done, as the styles of thought and diction of the two men were entirely dissimilar. Moxon was what might be called a "brilliant" man, quick witted and lively. He was very nimble in grasping an idea or situation and ready at once with responses. He dreaded the time when his faculties were dulled and his intellect passing on towards senility. He was the only member of the Staff who contributed "copy" to the Gazette in these early years. The little paper at this time had great difficulty in getting its columns filled.

Soon after the contributions of Pilocereus Senilis ceased, a contributor appeared who signed himself in imitation of Moxon, Pilula Ceruleus, a terminological inexactitude which seems to have escaped the notice of the Editor, but caused much amusement and chaff among the students.

"The Rush" at Guy's"

It was at this time that Sir William Gull was to have given his address at the opening of the Session, 1873, I think, in the Anatomical Theatre as usual, but the benches would not hold half the number who had come from all directions to hear him. So it was decided to adjourn to a large room at the Bridge House Hotel. When this was announced to the crowd waiting at the theatre door, there was immediately a wild rush to get seats. It created such a sensation in the neighbourhood of St. Thomas' Street that one of the weekly illustrated London papers gave a picture of it in the next number.

The Regent's Park Explosion.

I was in residence at the Hospital at the time, and I remember distinctly hearing, as I lay awake in bed that night, the terrific noise made by the explosion of a barge load of gunpowder on the Regent's Park Canal. It is impossible for words to describe the sound. It was too low in pitch to be imagined or described and yet so loud as to seem to be produced quite close at hand. I felt sure it was an explosion in St. Thomas' Street or Maze Pond, perhaps of the huge gas meter in the basement of the new Medical Wards. I anxiously waited for the sound of fire engines, but all passed off quietly and it was not until the next day that we learnt that it was miles away. I never heard such a terrific volume of sound in all my life. I have heard very big guns, but there is no similarity or comparison. The volume was so immense and the note so low.

I did not hear the address, although I was in the rush for the Bridge Hotel, being stopped before I got to the Hospital gates.

As I was not present to hear the lecture myself, I have lost any recollection that I may have had of it, but the size of the crowd of present and past Guy's men was a practical proof of the estimation in which he was held as a speaker. Different men have different views, hence the preference I have before alluded to, of many for Dr. Addison.

Examiners and their Reputations.

It is the same with examiners. Many dreaded what others feared least. Savory was looked on with opposite reputations. Partridge and Lane were considered by some as men who delighted to pluck men, but this was before my time, when they were younger men; for I always found them most agreeable. Evidence of this reputation is plainly seen in the lines of a semi-doggerel poem very popular some ten years before the birth of the Gazette.

(The following Horatian "Lay" was very popular among men who entered in the early Sixties. It was composed by the "Jackson" of the poem, I forget his Christian name, and was narrated to me by A. G. Mickley in 1867, six or seven years after the event. It was supposed to commemorate the "slaughter" of an unusually large proportion of candidates at one of the First College Examinations, but like the rest of the Horatian Legends, accuracy has been, I think, sacrificed for effect. The latter verses are slightly incomplete in a few of the words, but I think I have given all the verses.

THE FIRST COLLEGE.

Savory of Bartholomew's
By the nine gods he swore,
"Of five and twenty candidates,
I will pluck twenty-four."

Lane of St. Mary's Hospital,
To Savory, quoth he:
"I will abide at thy left side,
And pluck the men with thee."

Then outspake Dicky Partridge,
From King's I ween came he,
"I will stand at thy right hand
And spin the men with thee."

Bright shone the First of April,
E'en Lincolns Inn looked gay,
And smiling Phœbus rose to greet
The groups of students in the street,
Upon that All Fools Day.

Mickley, Dixon, Ilott, too,
Cum multis aliis, stood;
And chatted gaily of the glands,
The nerves supplied to feet and hands,
And of the salts of blood.

Apart from these stood Jackson,
Flushed with the flowing bowl,
Pectoralis major
Was a weight upon his soul.

While from his teeth, clenched tightly,
The words came thick and fast;
"Sternum and costal cartilage!
Oh! will my knowledge last?"

That day the fatal trio
Right well their oath they kept,
And on that April morning
Full many a student wept.

But last of all came Jackson,
Said they "This man's no ass,
We've plucked our four and twenty,
We'll let this fellow pass.)

As to Savory, if I did not actually prefer him myself to other examiners, I never objected to being examined by him. I do not say he was a mild and easy man; he could cram a lot of questions into a short space of time, but they were short, to the point, and easily understood, and, therefore, if a man was anything like well up, easily answered. The man I objected to was the one who would put long rambling questions of which the beginning was forgotten before the end was reached, and then it was doubtful what he really wanted: or the one who was keen on fads and unsettled points, and got irritable if his views were not then given. At that time Guy's men were taught that cirrhosis of the liver was a contractile process from the very beginning. Another school said that it began as an inflammation and swelling of the parenchyma, and therefore commenced as an enlargement. At the College of Physicians, Peacock, of St. Thomas's, was just getting me on the rack on this point when Wilks gave him a kick under the table, and he changed the subject. I think the one most justly dreaded was Holmes of St. George's. He was Ophthalmic Surgeon to that Hospital. He had himself an external strabismus, and he gave me always the impression that he was looking at my face with one eye and round the corner at my back with the other. His questions were long and ambiguous and not always easily understood.

In these days, the early Seventies, when up for the clinical, in the wards, we were given ten minutes to examine the part and collect our thoughts. I was taken up to a bed and shown a man's thumb and told that would be my subject of *viva voce*. It was an old dislocation. I went over the various kinds in my own mind and felt almost ready, when up came Holmes. He never asked me a question about the thumb or alluded to it, but pointed to a corneal opacity the man had and gave me twenty minutes on ophthalmic surgery. Fortunately, I had made good use of my time when dresser in the Eye Wards, or I don't know what would have happened. As it was he plucked every other man he examined and his colleague also let only one other through.

The terms "leucoma," "albugo," "nebula," etc., were sacred in the eyes of Holmes, and he required very exact definitions of the scope of their meaning; whereas at Guy's they were never heard. I never remember hearing Bader use any of them when dealing with opacities. To be dogmatic on non-important trifles and demand an accurate knowledge of non-essentials is, in my opinion, a mark of inferiority. There were others, too, who may have been once excellent men, but who ought long ago to have been put on the shelf, who endeavoured to discriminate between the fit and unfit candidates by making little traps. One, whose speciality was the testicle, invariably produced an object in spirit like a woolly football and asked what it was. Perhaps a prolonged examination at one's leisure might have succeeded in recognising it, but it was an utter impossibility for any student, in a few moments, screwed up to high pitch, to recognise the monster as a hæmatocele turned inside out. But the trick soon got wind and afterwards it was never mistaken.

Another such fossil once took me on a "dissected eyelid," but it had been turned inside out, and the left eyelid's concavity having been made to imitate the right convexity by being turned inside out, it was shown to the candidates in its new rôle, without one word of introduction or explanation. No youth, at all of a nervous disposition, could possibly, spontaneously, recognise the imposition, all he knew was that the appearance was quite unfamiliar. There was never any test of anatomical knowledge in this. It was unfair and unjust. Fortunately I was told that an inverted eyelid had gone into the room, so was not surprised when I got it.

Again, I mentioned being "keen on fads" as another objectionable feature in an examiner and not fair to a student. I had once to write a short paper on a given case, stating condition on examination, diagnosis, and reasons for such an opinion. I will not go fully into the case, but only allude to the point at issue, which to me was an important one, and

I believe this was one of the reasons of my losing a coveted honour.

It was a rough, strongly-built woman, very muscular and sturdy. She had a fair-sized pulsating swelling above each clavicle, which I diagnosed as double subclavian aneurism, giving my reasons at some length. It was a remarkable diagnosis, I admit, to make, but in my opinion my reasons were conclusive. When I met the surgeon afterwards who had the reading of these papers I asked him what *his* opinion was. "I have not quite made up my mind," he said, "except on one point and that is, it is most certainly not aneurism." "Why do you think so?" I asked, dejectedly. "Because," he said, with emphatic gesture, beating the air with his fists, "I never saw a case of subclavian aneurism, in a *woman*, in my life. It only occurs in men who have been used to heavy work with the arms, more especially with them raised above the level of the shoulder." My diagnosis, then, had been rejected because it was not in harmony with one of his home-made axioms. I was rebellious. The proper course, in my opinion, to take is not whether the diagnosis itself is right or wrong, but whether the physical conditions are accurately observed and a logical deduction drawn from them. The diagnosis alone, like the answer to a sum, may be copied; it is the observation and reasoning which count.

The woman stayed in long enough to admit of there being no doubt as to her having a double aneurism, but she was sent out without any operation being attempted. I ought in justice to add that the woman's employment was a pot hawker, and she was in the habit of carrying daily on her head, both arms steadying the load, a heavy basket of earthenware.

But the gold medal had worthily long gone its way, but I never forgot the lesson it taught me of the danger of being dogmatic and trusting too confidently to the lessons of a limited experience.

A Long "Chloroform" Case.

Speaking of this reminds me of a case in Job Ward, which will be found fully described in the reports of the ward clerk. It was a popliteal aneurism under Mr. Bryant. He wished to try the effect of prolonged digital pressure, and he asked me if I could manage to keep him under chloroform for 24 hours. I got the assistance of a number of men whom I knew could be trusted both for the anæsthetic and accurate pressure. I forget the total number, but two were on duty together, and stayed for an hour at a time. Each came on, if possible, twice. The experiment passed off without a hitch, not one single *contretemps* marred the proceedings. The patient lay quietly asleep for 24 hours. One man gave the anæsthetic, the other applying the pressure to the femoral. The fingers of one hand were first accurately laid on the artery, no *muscular* pressure being used, then the pressure was maintained, at an equable amount, by a proper padded weight.

It is impossible to maintain muscular pressure for long, and even then it is very uncertain and variable. When, in after years, I have seen men undertaking a simple case of anæsthetic and making so much commotion over arrested breathing, etc., that the operation becomes a secondary consideration, I have thought of my staff of anæsthetists and the popliteal aneurism. The result was quite successful, but I never heard of the treatment being repeated.

Unnecessary Refinements.

Antiseptic surgery was then making great strides and rapidly coming into favour, so that ligature of the femoral became one of the simplest and easiest of operations. Nowadays one can be always sure of the wound healing by first intention, and not being followed by any of the septic complications which formerly made its performance such a delicate consideration. Are students, now, I wonder, educated in such accurate surgical metaphysics as used to cling round popliteal aneurism, as to the choice of the high or low operation, the advantages and otherwise of the proximal and distal ligature, or both? and the distinctions and modifications of detail implied by former eminent writers on the subject such as Anel, etc.? I should think not. But aneurism was the favourite and pet subject of Timothy, and it was a necessary part of any man's knowledge, on going up for his Second College, that he should be well up in the lengthy tabulations contained in the learned monographs of the same, if he wished to come out creditably.

(To be continued.)

Marriage.

LAKEMAN—BEARE.—On April 18th, 1922, at the Congregational Church, Newton Abbott, William Symons Lakeman to Elsie, daughter of Mr. and Mrs. J. H. Beare of Courtlands, Newton Abbott.

Ed.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Empire Flag Day has passed, and we are left with little to remind us of our efforts, unless it be the notices in blue and yellow which one encounters wherever one goes in the Hospital, in the City, or in the Borough. All that remains to be done is to count the money, and if the generosity of the Borough givers is in any way typical of that of the rest of London, the result should be even better than was anticipated. Nurses, students and their helpers had taken their posts at a very early hour, positions commanding the bus routes, London Bridge and the railway stations being so well filled that there was little chance of any intending giver having to walk far to fulfil his intention. Perhaps it was the unusual spectacle of nurses in uniform selling flags, perhaps the strategic positions occupied, or the large number of flag-sellers, that compelled the attention of John Citizen and his lady friends. At any rate by the time the average College resident had dressed, breakfasted and strolled up to the station yard, there was not a solitary mortal to be seen who did not bear witness to the efficiency of the sellers.

The collectors in the West End may, and probably will, succeed in collecting a larger sum of money. Two or three American millionaires, influenced by the wiles of popular actresses, can do a great deal if they are put to it. But we doubt if there could be a more cheerful and ungrudging crowd than that upon which our collectors operated. Here and there, we hear, one met a man who "did not believe in hospitals." However, he generally gave his contribution, without needing much persuasion. Towards the end of the day a raid was made upon all the public-houses in the district, and the hoary old reprobates one sometimes finds in public-houses were in as kind a mood as any. It may be that their hearts were softened by the memory of happy Saturday evenings spent in the Front Surgery, following an unduly prolonged visit to the abode of Bacchus.

It was an exhausting day for the collectors, the heat-wave having attained its summit, and the Borough being probably the worst place imaginable in which to endure a hot English day. We know that their efforts were not wasted.

As our readers are doubtless aware, the sum which the King Edward's Hospital Fund organisers desire eventually to raise is £500,000, and it is hoped that the Empire Flag Day may be productive of as much as £50,000. We

hear that this amount has been reached, and even passed.

The Flag Day is, of course, but part of a campaign organised with the object of raising this £500,000, and we hope soon to publish a list of other functions arranged with this end in view. Among other events, the Inter-Hospital Sports this year are being held under the auspices of the Hospitals' Appeal Committee.

Whether the £500,000 will be successfully raised or not, we cannot confidently predict, although there is considerable justification for the view that the hopes of the Appeal Committee will be fulfilled. If they are, the more pressing needs of the Hospitals will be satisfied, and we shall be on the road to recovery after our long period of financial ill-health.

We congratulate the Committee of the Athletic Club upon the success of the Hospital Sports. In spite of the extreme warmth of the weather the attendance was good, and some fine performances were witnessed. C. L. Steyn succeeded in breaking the Hospital records which he created for the 220 yards and the Long Jump last year, and in addition did 100 yards in 10 secs., running from scratch, in the handicap event. P. K. Albertijn broke the Hospital record for putting the shot, and A. S. Gough, the winner of last year's half-mile and holder of the Hospital record, succeeded in improving upon his previous performance to the extent of 5 secs.

The meeting was very successful from all points of view. We are pleased to hear from the Athletic Secretaries that one of their desires—a desire to discover freshmen who show signs of athletic ability—has been gratified. Three or four men have been found who should do well for the Hospital in the next few years. In addition, some very good form was seen in the Honor Oak Park Coronation Scurry Stakes, the Hospital Derby.

We hope to publish a full account of the Sports in our next issue.

We are asked to remind Guy's supporters that the University of London Sports are being held at Queen's Club this afternoon. The Hospital stand a very fair chance of winning the Rosebery Cup, but much depends upon the whole-hearted support of those who are not able to compete.

One of the most valuable features of an interesting occupation, "running the Front Surgery," is the law which decrees that dressers shall write a diagnosis upon all cards given to cases sent up to the various out-patients' departments. The education of the dressers is by no means neglected. The initials P.R.D. marked prominently upon an out-patients' card indicate that the person who wrote them wishes a diagnosis to be returned, for the correction or confirmation of his own provisional diagnosis.

It is, naturally, conducive to greater keenness on the part of a student if he knows that his attempts at diagnosis are really going to teach him something, and finds that his cards are returned regularly. Fortunately Out-Patients' Officers and members of the Staff are very considerate in this respect, and the man in the Front Surgery has little cause for complaint nowadays. (We notice that the O.P.O.s occasionally register an angry protest against dressers who fail to write a diagnosis on their cards.)

One department, however, has never, to our knowledge, returned a diagnosis—Dental Out-patients. We must, in justice to our colleagues, assume that this is due to ignorance on the

part of the Dental A.H.S. as to the meaning of the symbol "P.R.D."

We feel sure that the Dental experts will be only too pleased, when we attempt diagnosis of conditions which we think need dental treatment, to help us in our attempts to appreciate their speciality, if only they know what is required of them. So we beg of them to return a diagnosis on all cards marked "P.R.D."

In this way a still stronger liaison between the dental and medical men at this hospital will be effected.

THE following letter has been addressed to the House Surgeon, Guy's Hospital:—

"Gentlemen,

I have a large number of splendidly bred Rabbits for sale two months old and very vigorous very prettily marked and make fine pets.

Thanking you in anticipation,

Yours obediently,

— —."

What would Mr. Bernard Shaw have to say to this?

THE many complaints which we have heard recently, as to the impossibility of attention at lectures while the noise of building of the new Anatomical Department is in progress, are undoubtedly well-founded, but we are not so sure as to whether a satisfactory arrangement can be reached.

After all, one cannot expect the new Department to be like Solomon's Temple, so that there is "neither hammer nor axe nor any tool of iron heard in the house," while it is being built.

But, as Mr. Lloyd suggests, the ingenious and fertile brains at the Medical School Office will doubtless devise a suitable arrangement now that they are aware of the existing difficulty.

Events of Interest for Fortnight ending June 10.

May 27.—2 p.m., University Sports at Queen's Club.

May 28.—Tennis, Guy's v. Dulwich (away).

May 29.—12 noon, Clinical Lecture by Mr. Doubleday on "Local Anæsthesia."

May 30.—Swimming, Guy's v. Marcians, at Walham Green Baths.

May 31.—Derby Day, Special Collection for United Hospitals' Appeal.
Clinical Lecture by Dr. Mutch on "Chronic Obstruction of the Ileum."
Tennis, Guy's 2nd VI. v. Grafton (away).
5 p.m., Prof. J. Babinski on "Des reflexes de défense," at the Royal Society of Medicine, Wimpole Street.

June 1.—4.15 p.m., Mr. Robert Milne, F.R.C.S., on "Operative treatment of Spinal Caries," at the London Hospital.
Swimming, Guy's v. Old Blues (2 teams), at Lambeth Baths.

June 3.—2.30 p.m., Cricket, Guy's v. L.C.W. & P Bank (away). Guy's 2nd XI. v. Staff, at Honor Oak Park.
Tennis, Guy's v. Surbiton (away).

June 4.—Tennis, Guy's 2nd VI. v. Gallery (away).

June 7.—Clinical Lecture by Mr. Davies-Colley.
11.30 a.m., Cricket, Guy's v. Downing College, Cambridge (away).
Tennis, Guy's 2nd VI. v. King's College (Honor Oak Park).

June 8.—University Swimming Gala at Goldsmiths' College Baths.

June 9.—4.15 p.m., Mr. Hugh Lett, F.R.C.S., on "Hæmaturia," at London Hospital.
Swimming, Guy's v. St. Bart.'s, at Pitfield Street Baths.

June 10.—Inter-Hospital Sports.
2.30 p.m., Cricket, Guy's v. Ciphers, at Honor Oak Park.
Tennis, Guy's v. Chiswick Park, at H.O.P.

Pass List.

Society of Apothecaries of London.

PRIMARY EXAMINATION, PARTS I. AND II.
April 3rd, 5th and 6th, 1922.

Anatomy.
J. L. Hopkins.

Physiology.
J. L. Hopkins.

Guy's Hospital Chapel.

The Annual Meeting of the Congregation was held on May 12th, in the Governor's Committee Room, the Matron, in the absence of the Superintendent, taking the chair. The Report, read by the Acting Chaplain, stated that the past year had been an abnormal one owing to a six months' interregnum in the chaplaincy. During this time the Rev. H. J. Embling, of the Southwark Diocesan Street Mission, had maintained the necessary minimum of Chapel Services and carried out all urgent duty in the wards, but was unable to do more than act as Temporary Chaplain until an appointment was made. This occurred at the beginning of September, when Canon Haldane, Precentor of Southwark, and the Rev. A. G. Harris of S. Philips, Kensington, took up the duties of Chaplain and Acting Chaplain respectively. They are assisted both in Chapel and in the wards by the other members of the Staff of S. Saviour's.

In spite of the temporary nature of his work Mr. Embling impressed his personality on the Hospital, made many friends, and, though now migrated to S. Kensington, continues to take the keenest interest in the Hospital and Chapel. We are very grateful for his help at a difficult moment.

Canon Haldane gave the special addresses in Advent. On Ash Wednesday the Bishop of Southwark paid his customary visit and preached to a large congregation. The special preachers in Lent also included the Archdeacon of London, Canons Woodward and Holland, and the Revs. C. E. Read and F. H. Gillingham. Dr. Hickox, F.R.C.O., of the Guildhall School of Music kindly provided an Organ and Violin Recital in November.

The balance Sheet was presented as follows:—

1921	£	s.	d.
Jan. 1. To Balance	59	6	1
Offerings, etc.:—			
Chapel	32	2	0
Bright	3	18	8
General Wards and Boxes	4	17	0
Sale of Books	1	9	6
	£102	13	3

1921	£	s.	d.
Dec. 31. By Flowers	26	12	7
By Sundries	6	10	5
Special Collections:—			
S. Andrew's Waterside	2	11	0
Samaritan Fund	9	3	2
C.E. Waifs and Strays	46	10	4
Southwark Diocesan Street Mission...	2	5	5
By Balance	9	0	4
	£102	13	3

Audited and found correct,
W. J. CURRY.

The new Chapel Committee was then elected and is constituted as follows:—

Ex-Officio members: The Superintendent, the Matron, the Chaplain and the Acting Chaplain.

Elected members: Sisters Lorna (Sacristan), Agnes, Beatrice, Bright, Dorcas, Dorothy, Lazarus, Light, Mannell, Naaman and Surgery, Staff Nurse Cornwall, and Nurses B. M. Davis, Iliff, M. A. Lloyd, Page, Sutton and Watkins.

Guy's '89 Club.

The 27th Annual Meeting and Dinner took place at Hotel Cecil on Wednesday, 10th May; the President, W. Tyson, in the Chair. There were also present, H. W. Beach, F. S. Brereton, C. E. Carpmael, R. E. Delbruck, G. L. Eastes, C. D. Edwards, C. A. Ensor, J. W. Ensor, R. H. Fagge, W. S. Handley, W. J. Henson, A. C. Hovenden, G. S. Hovenden, J. A. Howard, B. Instone, H. J. M. Milbank-Smith, H. A. Munro, A. A. H. Partridge, J. C. S. Peatson, B. G. Reynolds, L. G. Reynolds, F. W. Rowland, E. T. Shortland (Vice-President), H. J. Spon and F. J. Steward.

The Officers elected for 1922—23 are:—President, C. D. Edwards; Vice-President, R. H. Hayes; Hon. Secretary and Treasurer, H. J. Spon. The following new members were unanimously elected:—H. J. M. Milbank-Smith, Alfred Salter, G. Levick, H. B. Stoner, J. Robertson and Montagu Hopson.

That this annual function is greatly appreciated by men who entered Guy's during the years 1889—1893 inclusive is shown by the good attendance and by the number of letters and messages of regret for non-attendance received. On this occasion expressions of continued interest in the welfare of the Club came from C. H. Bryant, O. Beven, A. V. Clarke, R. F. Clark, E. Coleman, H. W. Collier, H. A. Duffett, L. E. V. Every-Clayton, C. H. Fagge, F. A. Godson, R. H. Hayes, H. T. Hinton, C. L. Hopkins, H. Hewetson, W. H. Jewell, M. P. Jones, C. E. Michael, H. A. Moffatt, J. Moore, W. G. Mumford, F. J. Nicholls, W. E. Robinson, W. J. Rowland, A. Scott-Turner, R. B. Stamford, J. R. Stenhouse, H. M. Stewart, E. R. Thomas and J. C. V. Wilkins.

There are now some 80 members of the Club, of whom about sixty maintain a keen interest in this re-union of old Guy's men.

The 28th meeting will be held (D.V.) on May 9th, 1923, at Hotel Cecil—will members abroad please note?

On the Etiology of Vomiting and Toxæmia during Pregnancy.

Paper read before the Physical Society by Mr. E. H. Richards.

Note.—The figures in parenthesis denote references.

Mr. Chairman and Gentlemen,—

It is not my intention to-night to advance any original observations or research, but merely to present a general review of the present state of our knowledge on this subject, as derived from an extensive examination of the literature.

Probably no physiological function is attended by such a high rate of mortality or of more or less permanent disablement as the function of reproduction. Not only in the human race is this fact illustrated, but when we consider the animal, especially the insect kingdom, do we realize the enormous wastage associated with the propagation of the species.(39)

But, even at the present day, there is only just beginning a gradual realisation of the gravity of the risks undergone during the pregnant state, in fact, as recently as 1907,(1) pregnancy was described as a harmonious and homogenous symbiosis—a description, as pointed out by Ballantyne in(2) 1912, only applicable when both mother and her child are healthy.

We have abundant evidence that pregnancy, even in the very early stages is accompanied by a far-reaching disturbance of the maternal economy. During the first three months after conception, the ovum is parasitic on its mother—placenta formation being not yet an accomplished fact, and it is during this period that we meet with that almost universal phenomenon of "morning sickness," which has hitherto been regarded by obstetricians as physiological, but unexplained, and accepted by prospective mothers as a natural consequence of their pregnancy and often as an omen favourable to the well-being of their child.

This nausea and vomiting is well-known typically to take place in the morning before breakfast and less often in the evening, especially when the midday meal is neglected, in other words, after the two longest fasts of the daily cycle.

Mottram(3) demonstrated that in some animals a short period of fasting was associated with some degree of fatty infiltration of their livers. This change was also demonstrated in the case of ill-nourished animals and those of a nervous type during pregnancy, and was considered by him to be physiological, but unexplained.

Now in cases of death consequent upon pernicious vomiting of pregnancy, which was always regarded as a peculiarly intractable development of the early sickness, post-mortem examination has shown varying degrees of fatty change of the liver parenchyma, apparently originating in the portal area of the liver lobule. Thus we have in some respect, a connection between repeated vomiting, fatty change in the liver and starvation.

It has also been observed that occasionally women, of their own initiative, have much relieved their unhappy state of repeated nausea and vomiting, by small and frequent meals, especially rich in carbohydrates.(4)

In this connection it has further been pointed out that in chloroform poisoning of the delayed type, we have a similar change in the liver parenchyma, and often severe vomiting, and in addition it has been shown that the introduction of large quantities of carbohydrate in a readily assimilable state into the individual is almost invariably a successful prophyllactic.

These facts led to the suggestion that these symptoms might be due to a carbohydrate deficiency, probably of the liver glycogen, and further that such a deficiency might exist during early pregnancy.

During these early months there is a heavy demand upon the maternal carbohydrate reserves, consequent upon the rapid storing of glycogen by the developing placenta for the future supply of the fœtus and further, when this placental development is complete, by the end of the third month, the vomiting usually ceases.(5)

In criticism of this theory, it may be objected that on these grounds, only one of the three clinical types of early vomiting is explained—the two remaining groups being:—

1. *Neurotic or hysterical vomiting* (so-called on account of the numerous well-founded reports of aleviation of symptoms by psychotherapeutic measures.)(6)

2. Toxæmic vomiting—characterised by the associated albuminuria.

Blumreich and Zunz(7) have pointed out that the pregnant state is nearly always associated with a hyperexcitability of the central nervous system—this increased excitability involves the sympathetic system, to which feature is often ascribed the undoubted formation of pressor substances early in pregnancy, giving rise to the slight increase in blood pressure generally observed, and perhaps accounting for the general slight hypertrophy of the media of the arteries described by Pankow. Now we generally consider that sympathetic overaction involves mobilisation of glycogen from the liver and in some cases, even a temporary glycosuria if the threshold value of the blood sugar be exceeded. Thus we can easily explain the vomiting following

on liver changes induced by the carbohydrate drain due to this sympathetic action, which being mainly psychical in origin, is presumably amenable to psychotherapeutic remedies, thus relieving the extra carbohydrate drain to such an extent that stabalisation of this part of the metabolism is rendered possible.

As to the remaining type of case, associated with a definite but slight albuminuria—undoubtedly some are related to the so-called toxæmias of pregnancy as far as etiology is concerned, but in others, the albuminuria may be merely a measure of failure of nutrition of the secreting epithelium, due to a general state of mal-nutrition, usual in these cases.

The addition of starvation, whether due to the vomiting or not, on to the results of the glycogen-storing mechanism of the placenta,(8) typically results in this so-called pernicious vomiting, which incidentally, closely resembles the symptoms caused by the sudden withdrawal of food as part of the treatment of diabetes mellitus by the original method of Allen.(9) But Gilliat and Kennaway(10) in criticising this explanation of pernicious vomiting, point out the greater heights to which the ammonia-coefficient in the urine, rises and the more rapid rise, compared with that observed in simple starvation, but then we have good grounds for believing that the hepatic function is somewhat impaired during apparently normal pregnancy in women, as presumably it is in Mottram's experimental animals.

As pregnancy develops, and the third and fourth month is approached, we have additional evidence of the striking and profound upheaval in the maternal system—signs which are now generally considered to be dependent upon altered function of part or whole of the endocrine system.

Later, during the second half of the pregnancy, other serious developments are prone to occur, which although they may be classified into distinct clinical types, have never the less been classed together as the toxæmias of pregnancy, presumably on the basis of the occurrence of an albuminuria of varying severity which is present in every case—developments which in a high proportion of cases, endanger the lives of both mother and child.

It is an established fact that albuminuria is of relatively common occurrence during pregnancy, 15 per cent of all pregnant women being the commonly accepted figure, but of these, the majority of cases are either of very slight or transient type, but in a certain proportion, the condition is intractable and more or less progressive in severity, usually complicated in the later stages by other manifestations of the state which, by analogy with other conditions known to be of toxic etiology, is considered as probably due to some toxin emanating either from the fœtus or its placenta—but the fœtus is probably innocent of the charge, because cases have been recorded in which this toxæmic state existed without the presence of an embryo, as in cases of hydatidiform mole.

Upon the study of this albuminuria and the later eclamptic state, an immense amount of clinical, experimental and anatomical research has been brought to bear and an enormous literature has accumulated during the last 30 years.

The earliest researches were directed to more or less elaborate chemical analyses of the urine, with the hope of discovering some abnormal constituent or some quantitative abnormality which would directly indicate the system or viscera at fault, but unfortunately, usually uncontrolled by any investigation of such fundamental importance as metabolic intake.

The results of very numerous observers in this line of work have been remarkably unanimous, but the main importance of their results has been in differentiating this condition from the well-recognised nephritic states, with which it was often and is, even nowadays, frequently confused.

The urinary picture in these cases is typically:—

1. An initial slight polyuria with diminished solid content.

2. An oliguria of varying intensity with an albuminuria varying up to such severity, that solidification occurs on heating.

3. An invariably high ammonia-coefficient associated with a total nitrogen excretion differing little from that encountered during clinically normal pregnancy, when nitrogen seems to be retained at the rate of about 1 gm. per diem.

This implies a low urea nitrogen percentage—Losee(11) working in New York found an average of 46 per cent in cases of eclampsia, while Macleod and other observers do not appear to find the figure below 70 per cent of the total nitrogen excreted.

4. A varying degree of acetonuria.

Now, this picture at once leads one to suspect some disturbance of hepatic function—the liver manufacturing the majority of the urea formed in the body, apparently from nitrogen compounds supplied by the portal vein.

But, as an alternative, it was thought that there might be an actual retention of urea in the blood, thus accounting both for the small amount excreted, and by analogy with uræmia, for the later convulsions of eclampsia—thus confusing the condition with a definite nephritis. This latter suggestion occasioned a concentration of investigation upon the physical and chemical constitution of the blood during pregnancy complicated by albuminuria.

On reviewing the reports of blood analyses by numerous observers, the striking feature is the unanimity with which normal values for the blood content of urea-nitrogen during normal and toxæmic pregnancy were found, in contrast to the invariably

high values encountered in cases of chronic nephritis complicating pregnancy—for instance Losee,(11) in examining a long series found the average results to be:—

For normal pregnancy 13·7 (always under 20) mg per 100 c.c.

Pre-eclampsia, 22.

And eclampsia 19·3 in contrast to values, as high as 100 mg. in the nephritic cases.

Otto Folin,(12) in reporting upon a large number of unselected cases including pregnant and non-pregnant individuals, gave as an average figure for the non-pregnant 11—12 mg. per 100 c.c., and a maximum of 9 mg. for the pregnant women, which together with a total nitrogen figure varying from 20—35 mg. per 100 c.c., even demonstrates an abnormally low urea content during pregnancy, tentatively suggested by him to be due either to some nitrogen remaining as amino-nitrogen for the fœtus or to a low threshold value of urea, indicating perhaps an increased toxicity. As an exception to these general results, must be cited those cases nearing a fatal termination having very marked oliguria or even complete anuria, in consequence of which are found values approximating to those encountered before or during uræmia terminating chronic interstitial nephritis—Otto Folin, quoting a case(13) having a blood urea-nitrogen content of 240 mg. per 100 c.c., in which uræmic symptoms developed a week later.

Similar results are reported concerning the creatinin content of the blood. Losee(11) finding for normal pregnancy 1·57; pre-eclampsia 1·55; eclampsia 2·25 mg. per 100 c.c. The rather higher value in cases of eclampsia being accounted for by the convulsive seizures and the usually accompanying oliguria —incidentally even in uræmia, a high value is not the rule, unless there be an accompanying anuria, when values in the region of 30 mg. per 100 c.c. have been reported.(13)

As previously mentioned, Folin determined in normally pregnant women, that the total non-protein nitrogen content of the blood varies between 20 and 35 mg. per 100 c.c., a value that is well within the normal limits of unselected individuals according to other observers, but his series of healthy persons shows the value to be between 28 and 30 mg. and generally to be lower than the values obtained in respect of pregnant women. This observation, coupled with his maximum estimation of urea-nitrogen at 9 mg., leaves us with 11—26 mg. of nitrogen in the form of ammonia and amino-acids circulating in the blood—a figure appreciably higher than the generally accepted normal value of 10—15 mg. per 100 c.c.

However, there is no close general agreement concerning these small differences, but it seems to be generally accepted that the blood picture (as determined by chemical analysis) in toxæmia differs little from that in normal pregnancy unless there be almost complete anuria when a retention of waste products would be expected as a terminal event.

Histological examination of viscera removed post-mortem has revealed lesions almost specifically characteristic of the condition.(14)

In the liver, typically are seen:—

1. Focal areas of cell degeneration and necrosis, irregularly scattered, usually in the periphery of the liver lobule.

2. Diffuse and confluent interstitial hæmorrhages associated with agglutinative(15) and fibrinous thrombosis and endothelial degeneration.

3. Extensive deposits of fibrin.

4. Massive liver necrosis, often involving an entire lobe or even the whole organ.

In the kidneys:—

1. General enlargement and often pallor, but no abnormal hardness unless there has been anuria before death.

2. Anæmia of the cortex.

3. Cloudy swelling, fatty degeneration and coagulation necrosis of the epithelium of the convoluted tubules with dilatation of, and presence of granular débris in their lumen. (Schmorl).(16)

4. Thrombosis of vessels associated with glomerular and interstitial hæmorrhages as described by Lawrence and Bradford.

5. And in those cases where the marked clinical features were oliguria or anuria apart from eclamptic seizures, focal necrosis of the kidney cortex is seen —being by some observers attributed to putrefactive changes, but recognised as a definite clinical and pathological entity by Jardine, Teacher and Kennaway—termed by them "Symmetrical necrosis of cortex."(17)

In the brain:—

1. Thrombosis associated with vascular degeneration is often seen—this apparently having some relation to the observations of Prutz, who states that 3 per cent of eclamptics die with massive cerebral hæmorrhage.

2. Also degenerative changes in the neurones are reported:—

(a) Eccentricity of nucleus.

(b) Fragmentation of Nissl's granules—while Prutz also states that 42 per cent. of the cases show cerebral œdema and 30 per cent. general intracranial congestion—which latter feature is only seen in about 10 per cent. of unselected post-mortem examinations.

In the examination of placentæ after delivery in a large number of toxæmic and apparently normal cases, infarcts, usually of the white variety are frequently encountered—Meyer states their incidence at 2 per cent., being 4 times as common in cases with albuminuria, while Rossier reports 17½ per cent.

with about 81 per cent. in albuminurics, and Whitridge Williams(18) finds them in 63 per cent. of all cases. But, on the other hand, in many cases of acute and rapidly fatal onset—no placental infarcts are to be seen at first by naked eye examination, but it was shown by James Young(14) that microscopical examination or naked eye examination after immersion in formalin solution reveals infarcts of the red variety, which he considers form an early stage in the formation of the obvious white infarct.

Now, there has been much controversy over the mechanism of formation and the pathology of these infarcts.

Microscopical examination of an infarct reveals vascular engorgement and œdema of the chorionic villi, resulting in their crowding together and consequent obliteration more or less completely of the intervillous spaces, in which there is evidence of fibrin deposition—a fact definitely pathological and moreover, constant in appearance.(14)

On anatomical grounds, it is stated that each placental cotyledon has a distinct and separate maternal blood supply and they are divided from each other by thin partitions of decidua stretching from the uterine wall to the applied surface of the placenta, preventing detachment and shearing between these structures. Also, on very strong evidence, it is affirmed that the placental villi depend for their nourishment upon the maternal blood which is circulating in the intervillous spaces—this circulation being in part maintained by the rythmic systole of the uterine muscle which is known to occur continuously during the latter part of pregnancy, and it is further stated that stagnation in these spaces is an abnormal occurrence.

The pathological appearances of an infarct therefore point to interference with the nutrition of the placental villi, and apart from a hæmatogenous toxin (which would, however, probably not give rise to local infarction but to a general involvement of the placenta), stagnation of blood in the placental spaces either from arterial or venous obstruction of the maternal vessels, seems to be the simplest explanation, and one which is borne out by the histological findings. Blocking of the arterial supply to a cotyledon, dependent upon an exaggeration of the normal process of endarteritis found in the uterine arteries towards the end of pregnancy, would be sufficient to cause infarction, but apparently this endarteritis has never been demonstrated to have advanced so far, in cases where syphilis could be excluded, and furthermore, the association of infarction with marked and definite retroplacental hæmorrhage is well-founded—this association being explained upon the supposition that the placental veins become obstructed, increase of pressure and stagnation in the placental spaces following, resulting in separation of the placenta to a variable extent by the rupturing of the decidual strands previously mentioned.

Essen Möller(19) first called attention to the frequency with which accidental hæmorrhage is accompanied by albuminuria. In Berggren's(20) 8 cases albuminuria was marked in 4, in Zweifels' series(21) 38 per cent., in Young's(14) 29 cases, 34 per cent., and in Gorden Lay's(22) 60 per cent. Thus, according to different observers, albuminuria occurs in from 38 to 60 per cent. of cases of accidental hæmorrhage, in contrast to the accepted figure of 11 per cent. albuminurics in average unselected series. From these figures, it seems tolerably certain that the hæmorrhage is not caused by the supposed toxic condition giving rise to the albuminuria, since many cases of accidental hæmorrhage are unaccompanied by any manifestations of toxæmia—if this conclusion be justified—what factor is causing the hæmorrhage?

Schmorl(16) discovered masses of syncytium in the pulmonary vessels during autopsies on pregnant women and he originally advanced the theory that the whole train of events here considered might be due to a general poisoning with the products of autolysis of these isolated pieces of chorion. This idea was somewhat supported by Abdenhalden's(23) demonstration of proteolytic ferments in the serum of pregnant women as early as the end of the second week after conception, and by Leith Murray(14) who demonstrated complement fixation by serum of normally pregnant women between the second and fourth months when incubated in the presence of an antigen of placental extract—Fieux(24) and Mauriac, Bar and Daunay(25) independently showed this reaction to be negative after the fifth month and in the case of non-pregnant women.

Veit,(26) having in mind Schmorl's discovery, suggested that the venous obstruction necessary to initiate a retroplacental hæmorrhage might be due to embolism by detached villi or even by an extension of villous growth into the veins themselves, but such a massive and complete obstruction has not yet been demonstrated.

Essen-Möller(19) and Young,(14) however, have described a general placento-uterine apoplexy in a case of severe accidental hæmorrhage in which they found a marked dilatation of the vessels in the uterine wall, with extensive hæmorrhagic extravasations and thrombosis extending into the ovarian and uterine veins, and they advanced the suggestion that the condition might conceivably be an exaggeration of the normal process described by Gorden Lay,(22) in which towards the end of pregnancy, slight vascular degeneration associated with hæmorrhagic extravasations in the lower uterine segment occurs.

That some abnormality of the circulating blood, following upon placental infarction with retroplacental hæmorrhage, exerts its toxic effects upon the various viscera seems now undeniable, but in spite

of the vast amount of work, involving serological and inoculation experiments, accomplished we are still far from elucidating its nature and origin definitely.

One school of thought maintained that the primary factor was the dissemination of toxins resulting from a disturbed intestinal function—a conclusion supported by very good evidence.

Barnard,(27) after an extensive examination of the urine of 244 unselected women, 160 of whom were in different stages of pregnancy, found a definite urobilinuria in 72 per cent. of the pregnant and 26 per cent. of the non-pregnant cases, but after discounting all cases in which liver disease or hæmolysis could not be confidently excluded, arrived at the figure of 20·6 per cent. and 0·2 per cent. respectively for the two classes; and in the same series discovered a definite indicanuria in 45 per cent. of the pregnant and in 15 per cent. of the non-pregnant. Now, urobilin is considered to be formed by the decomposition of bile by the action of intestinal organisms and is a definitely abnormal constituent of the urine, while indican is formed from the tryptophane of the diet by the action of putrifactive organisms.

A theory based upon intestinal toxæmia seems to ignore the relation of the symptoms to the uterine contents, for in the majority of cases, eclamptic or toxæmic symptoms rapidly disappear after delivery and occasionally after death of the fœtus, even if it be retained, and in about 16 per cent. of cases with fits, convulsions are post-partum in occurrence, but it seems conceivable that an increased toxicity of the portal blood may directly conduce to hepatic deficiency, a function which is assumed to be below normal in early pregnancy, from a consideration of its pathological appearances in Mottram's animals, this resulting in a lessened power of detoxication—thus establishing a vicious circle, but never the less, it is a significant fact that during the food shortage in Germany consequent upon the late war, eclampsia was the only condition which showed a markedly decreased incidence.

Other investigators more or less confined themselves to the quest of the hypothetical toxin.

Dold, in 1911,(33) working with saline extracts of various viscera and Obata,(28) eight years later, with extracts of both normal and eclamptic placentæ, showed that their intravenous injection into certain animals, usually mice, was followed by toxic effects —the latter observer reporting the appearance of sudden excitement after an interval of 10—30 secs. (rarely 60 secs.), followed by brief clonic and tonic convulsions, urgent dyspnœa, coma and finally death —the whole seizure lasting under 3 minutes.

Other workers have obtained similar results, but Lichenstein(29) produced similar fits and death with widespread intravascular thrombosis by injecting suspensions of very fine sand.

Further, they showed that these toxic effects were diminished or neutralised by simultaneous injection of, or by previous incubation of the extract with ordinary serum, whether obtained from men or women, but the serum of eclamptic women was shown to have about half the antitoxic properties possessed by the other sera in about equal degrees.

No progressive immunity to these toxic bodies has yet been demonstrated as pregnancy develops.

James Young,(14) some years ago, reported a long series of inoculation experiments with animals, using human placentæ, combined with a rigid control—briefly he stated that:—

1. Injection of freshly expressed placental juice produced death, but no convulsions or typical visceral changes—Weichardt, Pilz and Freund had previously anticipated these results.

2. Injection of suspensions of powdered dried placentæ after autolysis for a week, resulted in convulsions and muscular spasms after an interval of 20—30 secs., lasting about 20 minutes, followed by coma and death, but no characteristic liver or renal changes were found post-mortem—incidentally Dixon-Taylor, in 1907, described an adrenaline-like body present in juice of autolysed placentæ, later shown by Rosenstein to be absent in fresh placentæ—but it is well-known that pressor substances are readily formed during the autolysis of any flesh.

3. Saline extracts of placentæ, resulted in non-fatal convulsions lasting about 30 secs., but after repeated injections, post-mortem examination revealed characteristic liver changes.

4. Injection of glycerine extracts was followed by muscular spasms only—no typical convulsions, but post-mortem the liver and renal changes were found to be well-marked.

These experiments indicate the existence of at least two toxins having different affinities—the one affecting the nervous system and the other giving rise to necroses in the viscera.

Leith Murray(14) aptly compares the eclampsia toxin with that of cobra venom, which has been shown to have at least four constituents:—

1. Neurotoxin.
2. Hæmagglutinin.(15)
3. Endotheliolysin.
4. Hæmolysin.

Whereas, the former has only been shown to comprise the three first-mentioned components.

But the remarkable fact is that he has shown that there exists an antibody to this cobra venom in the blood of 80 per cent. of primiparous and of 66 per cent. of multiparous women during pregnancy, but he gives no figures in the case of eclamptic women.(14)

Furthermore, he states that the addition of calcium to the venom reduces its toxicity(37)—this raises to question the significance of the increase in calcium content of the blood as pregnancy progresses—especially as Halford(38) states definitely that the administration of calcium often diminishes the albuminuria and œdema in cases of pregnancy toxæmia.

Now, many serious criticisms have been levelled against the theory connecting placental infarction with toxic invasion of the blood stream.

Why do the symptoms in some cases disappear spontaneously after intrauterine death of the fœtus, even if the latter be retained?

If we imagine an extensive separation of the placenta resulting in death of the fœtus, associated with such a degree of retroplacental thrombosis that all the infarcted areas of the placenta are isolated from the maternal blood stream—autolytic products will be prevented from dissemination, thus toxæmic symptoms will not appear, but if this isolation be inefficient, toxæmia will result. Thus a sudden increase in retroplacental hæmorrhage may easily result in the isolation of placental tissue previously giving rise to poisoning.

Further, this conception supplies a tolerably satisfactory explanation of post-partum eclampsia—pieces of retained placenta in the absence of complete thrombosis in the uterine spaces, may liberate sufficient products of decomposition into the blood stream to cause symptoms—but if this explanation be correct, why are not eclamptic manifestations more commonly observed in cases of retained products?

Rosenstein's work showed that the pressor substances due to placental autolysis, are only liberated when the enzymes act in the presence of micro-organisms—Müller and Albert confirm these observations, but point out the usual occurrence of pyrexia in eclampsia and even suggest that there may be a latent endometritis in these cases. This seems improbable, but on this assumption, should not toxæmia be especially rife in cases of retained products, when conditions are ideal for bacterial invasion and multiplication?

The results of treatment based upon this mass of scientific evidence, confirm the main conclusions drawn therefrom in a striking manner.

The famous formula of Stroganoff of Petrograd, which since its conception has been so widely modified, in essence consisted in the free use of morphia and other sedatives combined with simple diaphoretic and eliminative measures and strict isolation in a darkened room, until after delivery by manipulative or natural methods according to individual indications.

In reporting the results of 400 cases treated on this plan, he estimated maternal and fœtal mortality at 6·6 and 21·6 per cent. respectively, an enormous reduction on the 30 and 50 per cent. mortality usual at that time. But in reviewing the treatment on these lines, as advocated by different observers, one is struck by the wide differences in opinion upon the indications for delivery, whether artificially or by induction of natural labour, and also by the different interpretations placed upon the mechanisms by which these measures conduce to a satisfactory conclusion.

Many consider that Cæsarian Section, for instance, exercises its beneficial effects in virtue of the amount of blood inevitably lost consequent upon the operative procedure, but there is abundant evidence that venesection in some cases with very high vascular tension and frequent fits, leads to improvement in the condition, but on the other hand, MacAllister(30) does not consider venesection to be justifiable in view of the known deficiency of free alkali in the circulation because of the acidosis, unless combined with intravenous infusion with alkali—while discussing this aspect of the subject, he incidentally mentions the prognostic value of a determination of the alkali tolerance.

Following upon the reports of the serological experiments among animals, results of treatment along these lines soon followed. Freund(35) reported cessation of fits in 6 severe cases of eclampsia following the injection of 20—80 c.c. of ordinary horse serum, and 3 similar successes after injection of serum from a normally pregnant woman.

Mayer(36) reports relief after 3 injections of 10c.c. of human serum at 3-daily intervals in a case of eclampsia with fits, coma and 7 per cent albuminuria.

These reports on the efficacy of horse serum in treatment, raises the question as to whether the reaction is not of an unspecific nature comparable to the well-known protein shock, instead of a specific reaction between antigen and antibody.

More recently, Blair Bell(34) reports upon a very severe case with fits, albuminuria, œdema and semi-coma, with continuance of the symptoms unabated after delivery of dead twins—transfusion with 500c.c of human whole blood without previous venesection resulted within 8 hours in:—

1. Marked increase in urinary secretion.
2. Reduction of albuminuria from 12 per cent. to a trace.
3. Reduction of the ammonia coefficient in the urine from 22 to 4·8 with a disappearance of the acetone.

On the other hand, other observers have adopted more symptomatic treatment. Wallace,(31) impressed with the results obtained by Fox in cases of tetanus, in which he reported a recovery rate of 50 per cent. after intrathecal injection of $MgSO_4$—applied similar treatment to cases of eclampsia showing severe and frequent convulsions—and reported two cases in which a rapid diminution of the fits and increase in urinary

function resulted, followed in both cases by recovery, but not until after delivery.

And lastly, Clifford White,(32) reports two cases of severe eclampsia with marked oliguria, in which the urinary excretion either remained inadequate or completely ceased after delivery—decapsulation of both kidneys resulting in almost immediate restoration of urinary function; followed by a good recovery in both cases.

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Change of Name.

I, Frederic James, heretofore called and known by the name of Frederic James Smith, of 12, Wickham Way, Beckenham, Kent, Medical Student, hereby give public notice that by a Deed Poll dated the 30th day of January, 1922, duly executed and attested and enrolled in the Central Office of the Supreme Court of Judicature on the 21st day of April, 1922, I formally and absolutely renounced and abandoned the said surname of Smith and declared that I had assumed and adopted and intended thenceforth upon all occasions whatsoever to use and subscribe the name of James instead of Smith and so as to be at all times thereafter called or known and described by the name of James exclusively.

Dated the 26th day of April, 1922.

FREDERIC JAMES,
late FREDERIC JAMES SMITH.

Hæmaturia.

CLINICAL LECTURE BY MR. A. R. THOMPSON.

GENTLEMEN,—Hæmaturia is too commonly regarded by the lay public, and I regret to say apparently by some medical men, as a disease of little importance. Hæmaturia is, in fact, a symptom of grave significance. I will write up a list of the causes of hæmaturia which may be useful to you in forming an opinion as to any case of hæmaturia which you may see in practice.

The common causes of hæmaturia are—

1. Growth of the bladder.
2. Enlargement of the prostate gland.
3. Renal calculus.
4. Acute nephritis.
5. Bilharzia (Egypt).

Less common causes of hæmaturia are—

6. Serious heart lesions.
7. Purpura.
8. Chronic nephritis.
9. Tuberculous disease of the kidney.
10. Growth of the kidney.
11. Cystitis.
12. Injuries involving the upper urinary tract.

Before we consider the cases which I have to show you to-day I will put up a little list of the degrees of hæmorrhage.

1. Really serious hæmorrhage which if allowed to continue will, in the course of a few hours, lead to the death of the patient unless treated surgically, is, in my experience, most common with kidney lesions.

2. Serious hæmorrhage which may lead to the patient becoming very anæmic looking, but whose life is not put into immediate danger by it, is usually associated with a growth of the bladder.

3. Less degrees of hæmorrhage are associated with any of the above causes.

Never be misled by a clot remaining in the bladder, and staining the urine, into thinking that active hæmaturia is continuing, but it is far safer for the patient and for you to make this mistake than to neglect a real hæmaturia.

As an example of really serious hæmorrhage in which the origin was renal, I will quote the following case, the exact cause of which I do not know. A male, aged 55, consulted me for hæmaturia. I cystoscoped him and saw blood pouring down from the left ureter. As he was very anæmic and in poor condition, I cut down upon the left kidney, incised it, and found it darker than usual and with a fair amount of fat in the pelvis. As the patient did very badly under the anæsthetic, I sutured the kidney wound and sewed up the wound in the abdominal wall. The patient did very well for ten days, but bleeding began again, and was of such a nature that after a week of it Dr. Ryffel found only 25 per cent. hæmoglobin. Large doses of laudanum were given, and four days afterwards 33 per cent. of hæmoglobin was found, though apparently the degree of hæmaturia was the same as before.

A son of the patient gave blood for purposes of transfusion. Mr. Eric Scott gave ether. I excised the kidney; the patient rallied from the operation, another son giving more blood after the operation. The patient had no more bleeding and was convalescing at Brighton in four weeks after the operation. He is alive and in good health at the present time.

I regret to say that the kidney was put into ordinary surgical formalin and went putrid before it could be examined, but the proof that it was responsible for the hæmorrhage, so grave as to endanger the life of the patient, is supplied by the fact that the bleeding ceased after excision of the organ. There was no reason to suppose that the bleeding was caused by the first operation.

I quote this case as an example of really serious hæmorrhage occurring as a result of a renal lesion.

I have now to show you three cases of hæmaturia, one due to growth of the bladder, one to enlargement of the prostate and growth of the bladder, and one due to recurrent growth in bladder.

The first case is that of a man, aged 35, sent up to the hospital by Dr. A. V. Moberly, of Surbiton, who recognised the man's serious condition.

Six and a half years ago he consulted a medical man for hæmaturia; since then he has seen several medical men who apparently regarded the condition as not being very serious. In fact it was not until he consulted Dr. Moberly that the gravity of his condition was re-

cognised. After his admission to the hospital 10 minims of laudanum were administered every four hours. He was kept in bed and put on a light diet. No instrument was passed. At the end of a week I attempted to cystoscope his bladder, but the bleeding could not be stopped, and, moreover, the cystoscope impinged against a mass in the bladder, so that a view of the bladder was impossible. I, therefore, cut down upon the bladder and found the largest growth of the bladder I have ever felt. The base was rather narrower than the rest of the growth, but anything in the way of removal was clearly negatived, as the patient was not in a good enough condition to allow me to attempt removal. A small piece of the growth was removed for microscopical examination, and Dr. Nicholson reported it to be "infiltrating," and therefore malignant and of an epitheliomatous nature. I sutured the bladder mucous membrane to the skin and the hæmorrhage ceased.

Mr. V. E. Lloyd has performed diathermy several times on him, and I am convinced the growth is smaller. At the present date, April 25th, the patient looks very much better and has put on weight. If his condition continues to improve we may be able to excise the growth.

I think we may conclude from this case that hæmaturia is not a disease of no importance, but is, on the contrary, a symptom of very grave significance.

The next case is that of a man, aged 73, who was passing blood in his urine and had a very large prostate palpable through the rectum. The commonsense conclusion was to associate the two conditions, and not to catheterise the case before operation. Retention was not a marked feature of the case.

I opened the bladder, Mr. Lloyd giving the anæsthetic, and found an enlarged prostate and a papillomatous growth upon the right side of the base of the bladder, but having no apparent connection with the enlargement in the prostate. I placed two Spencer-Wells forceps upon the pedicle of the growth, and cut between the two forceps and removed the growth with one pair of forceps, leaving the other one upon the pedicle. This was removed at the end of forty-eight hours.

Mr. Lloyd considered that the patient's condition was good enough to allow of removal of the enlargement of the prostate, and I considered that his condition was as good as, or even better, than it might be in five or six weeks' time, and removed the adenoma of the prostate. Although the patient caused my house-surgeon, Mr. R. E. Williams, some anxiety after the operation, he did well, and was discharged with no recurrence of the hæmorrhage.

I will ask you, gentlemen, if you really think that in this case the hæmaturia was a disease of no importance? Was it not rather a symptom of very grave significance?

The third case is that of a male, aged 68, who has hæmaturia which is not of urgent or immediate importance, but who is nevertheless in a very bad way indeed. In addition to the hæmaturia, he has pyuria. The cystoscope reveals an ulcerating necrotic mass near the right side of the base of the bladder, and also a button-like vascular, non-necrotic, mass projecting into the bladder from about the middle of the upper surface. His history is that 11 years ago, and again 5 years ago, he had his bladder opened for the removal of growth at some other hospital. He has now, in addition to the bladder growth, a secondary deposit in the rectus muscle.

I have had three other cases which have been operated upon at other hospitals for growths of the bladder with secondary deposits in the rectus muscle. Such a termination of growth of the bladder is, however, not so common as ascending nephritis.

Finally, I would ask you a series of questions. Does not hæmaturia indicate a solution of continuity of the mucous membrane somewhere in the urinary tract? You will say yes. Does not solution of continuity of the mucous membrane indicate possible sepsis? You will answer yes, and you will at once add that sepsis in the urinary tract means involvement of the kidney, either directly or by ascending nephritis; and death. I hope after these remarks you will not regard hæmaturia as a disease of no importance, but as a symptom of grave significance.

Addendum—

Dr. Moberly's case was not diathermised again, as Mr. Lloyd thought all the good had been done by it that could be. He was allowed to pick up strength a little, and I excised the growth in great part. He has done well after the operation.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Hospital Policy of the Labour Party.

DEAR SIR,—With reference to Mr. Rogers' letter in which he speaks of the servility of nurses to their seniors, do you not think that the junior men, if not outwardly so apparently servile to their superior officers are certainly more in awe of them than the nurses are of the sisters?

How often do we notice in the wards and in the surgery that the dressers will come for instruction about their work to any member of the nursing staff in preference to going to the H.S. or the O.P.O. I think the night nurse is the only nurse who opens the door for a house officer, and that is because she fears he will make a noise in shutting it.—Believe me, your sincerely,

A SENIOR NURSE.

Guy's Hospital,
London, S.E.1.
May 5th, 1922.

[We regret that we cannot publish any further correspondence on this subject.—Ed.]

Punctuality.

DEAR SIR,—May I venture to draw the attention of the Reconstruction Committee to a much needed reform, which does not appear to have been considered in their report. I refer to the lamentable lack of punctuality, which is so prominent a feature in the characters of certain members of the Staff. It is no uncommon occurrence for students to spend an undue proportion of the day in such unsalubrious spots as the Colonnade or the barren spaces between the medical wards.

May I suggest as a possible remedy that members of the Staff, unless able to supply their ward clerks or dressers with a satisfactory explanation, should pay a fine of a guinea for every quarter of an hour they are late. The money thus obtained might be handed over to the students as a fund for the purchase of leather overcoats, in order that their health may not suffer from prolonged exposure.—I remain, Sir, yours truly,

PATIENCE EXHAUSTED.

Guy's Hospital,
London, S.E.1.
May 13th, 1922.

[Overcoats? This weather? Oh! Mr. P. E.!]

Cash Payments in the Conservation Room.

SIR,—Through the medium of your columns, which seem to be the recipient of complaints or suggestions from subscribers, regarding those things which cause trouble or annoyance to members of the Staff or students of the Hospital, may I be allowed to voice a complaint which I know has the support of the majority of dressers in the Dental Conservation Room?

The present system of cash payments by the patients is this: when a patient's mouth is inspected by the dresser, he diagnoses to the best of his ability, and records his opinion, as to the teeth that require treatment. A House Surgeon is searched for, and requested to "allot the case." This means he confirms or alters the dresser's diagnoses and authorises work to begin. The dresser prepares a cavity, and usually then, and not till then he mentions payment to be made by the patient. Generally—in fact in about 90 per cent. of the cases—the dresser goes to the compound desk, obtains a supply of materials authorised for the filling, paying out of his own pocket the amount required. In quite a number of cases, patients come to the Hospital without any money but their bare fare home, and then the dresser must perforce allow the patient to go away, promising to "bring the money next time." If a dresser does two or more fillings in one session, then he is all the more out of pocket.

I suggest that there should be absolutely NO cash transaction between patient and dresser. Some member of the Staff should be on duty always to receive cash, and to ensure that patients are given due and full notice of the amount of money anticipated to cover the cost of treatment.

In every case it would be far more satisfactory were cash payments made before treatment be started. In the case of patients who prefer gold, they might be charged the minimum 2s. 6d., and notified that there might be more to pay on completion. Incidentally advance payment would ensure patients returning for completion of treatment.

There is no reason why dressers should be placed in the position of having to ask the patient for money, or even to mention the subject at all, unless it be that matters have been allowed to slide into the present deplorable state.

May I ask that this be brought to the notice of the responsible Authorities, or that I may be informed through your columns of the correct procedure for registering any grievance.—I am, Sir, yours etc.,

T. O'R. CLANCY.

Guy's Hospital,
London, S.E.1.
May 14th, 1922.

A Correction.

DEAR SIR,—I thank you for the last War Number of the "Guy's Hospital Reports."

There is no catching up an error. My name appears as mentioned in despatches, 1915. The first mention I received was from my college at Oxford, I wrote and denied it. The *Times* was quoted, and true, my name did appear there, but it was a

mistake for my brother, H. R. The next was in the GUY'S GAZETTE, which I also tried to correct. About three months ago arrived a parchment from Winston Churchill via Louis Botha and the King thanking me for my valuable assistance. Now comes the Guy's "Reports."

Well I have not sold my birthright to a younger brother, but I have not any wish to usurp his due deserts.

I did not join the Forces until 1917 and have not been within 1,000 miles of G.W.S.A. Contrariwise my brother, H.R., joined in August, 1914, and finished as a Major in S.A.M.C. after the Armistice.

The Report should therefore read:—

H. R. MULLINS, Major S.A.M.C., Served in G.S.W.A. and France, 1914—1918—also he was given the O.B.E. and twice mentioned in despatches.

R. C. MULLINS, Capt. Guy's Hospital XV., 1899 and 1900. Mentioned in Guy's GAZETTE in those years!—Yours truly,

R. C. MULLINS.

The Grotto,
Grahamstown,
Cape Colony.
April 15th, 1922.

DEAR SIR,—We venture to ask for your help in connection with a subject which has not received the attention it deserves.

Except for the large attendances at first XV. Rugger matches, all Hospital sports seem to be of little interest to others than the actual participants. This absence of a proper "esprit-de-corps" must be due either to want of knowledge or lack of interest, but it is of very real meaning to the clubs that are endeavouring to reach, and maintain, a commanding position in Inter-Hospital Sport. The Summer games are particularly ill-attended; entries for the Sports are few in comparison with the number of students. We won the Junior and reached the Final of the Inter-Hospital Cricket Cup, but it is rarely that more than a handful of men will come to watch home cricket matches, even against good clubs. Spectators at tennis matches are conspicuous by their absence despite the fact that we secured both the Senior and Junior Inter-Hospital Cups; and similarly swimming contests evoke little interest, although all the Inter-Hospital Swimming Cups came to Guy's last year.

Active encouragement is an incentive to a higher standard; the lack of it can only tend to discourage not only those who are endeavouring to raise it and keep things together, but also those recruits whose interest and help are so badly needed.

We hope, Sir, that this brief letter will awaken in the Hospital that keen and enthusiastic support for our summer games, which is so marked in the Staff and Students, in connection with our Rugby Football Club.

We trust that all members of the Hospital will recognise the justice and necessity of our plea.—We are, Sir, yours, etc.,

GUSTAVE COHEN—*Swimming.*
A. G. ENSOR—*Cricket.*
A. GORDON—*Tennis.*
S. V. STRONG—*Athletics.*

Guy's Hospital.
May 23rd, 1922.

DEAR SIR,—May I draw attention to a condition of affairs which, I am sure, is a source of annoyance to a considerable number of students? Owing to the work going on at the back of the Medical School in connection with the New Anatomical Department it is often quite impossible to hear what is being said, during lectures delivered in the Anatomical Theatre.

And even where the noise of hammering and what-not is insufficient to drown the voice of the lecturer, it is quite sufficient to distract one's attention and the benefit of an excellent lecture is diminished in proportion.

The obvious solution is to hold the lectures elsewhere, but perhaps the Powers That Be can find some more obscure, though better, method of ridding us of this nuisance.—I am, yours faithfully,

N. L. LLOYD.

Guy's Hospital,
London, S.E.1.

Notices.

Guy's Hospital Dental School.

Clinical Assistant in the Children's Department.
April—July, 1922, Mr. T. F. Fox.

The Thirty Club.

The first Dinner of the Thirty Club will be held at the Trocadero Restaurant on Saturday, June 17th, at 7.45 for 8.0 p.m. Members who intend to be present and also those who are bringing guests are requested to inform the Hon. Secretaries by June 2nd.

J. J. CONYBEARE.
V. E. LLOYD.
Guy's Hospital.

How He Joined the Army.

Some men were born into the army, some volunteered for it and some were thrust into it. The relator of the following experiences was overheard at the Halfway House where pensioners fortified themselves at midday for the ordeal of examination by a Pensions Board, and incidentally loaded their breath with evidence which later on contradicted their statements as regards alcohol.

The narrator was a stupid looking individual with a face which all through the story showed as much expression as a leg of mutton.

Say mate, when did tha join up?

Nanteen eighteen!

Oh! Ah thowt as tha'd been aw through!

Not lakly. Tha sees when t'war brok out ah were makin good money so ruddy army were no ruddy use to me, an when war got goin proper ah were doin reet well.

Then they brought in this 'ere Compolsory Service Act an' it looked as if they would have me whether or not. Ah thowt to mysen tha mustna lose chance of aw this good brass, so ah schemed to let on as ah were deaf.

An they had me up before two Medical Boards an they cudna mak nowt outer me, so they let me alone.

Then they got desprit an they cawd me up to go before Specialist Board.

When ma turn come ah were shown in an specialist were a sawny lookin yong chap an ah thowt to mysen. Well! If ah've beaten them other old beggars ah reckon ah con beat this yong beggar to. So ah taks off coat an hat an lays em down an he grabs ma elbow an taks me into corner an says:—

"Say after me"—Ah took no notice so he pokes fingers between ma ribs an says:

"Repeat after me."—"Eh? what d'yer say?"

"REPEAT AFTER ME."—"Ah've got yet master, go ahead."

"Ninety-nine!"—"Eh?"

"NINETY-NINE!!"—"Nicely fine."

"NINETY-NINE!!!"—"Ninety-nine."

"Eighteen!"—Ah heard nowt.

"EIGHTEEN!"—"A team."

"EIGHTEEN!!"—"Eighteen. Say master are they aw nombers?" He nods is ed an says yes, an after that he tried a lot of em; an when he shouted em ard ah mostly got em right an when he didn't ah did as well as ah could, until at last when he'd fair cracked droms of ma ears an got hisself hoarse her turned round to clurk an says: "This pore silly blighter's no use to t'army, mak out his ruddy discharge papers an sling t'blighted ijjit out."

An then he turns round an says to me in a tired sort of way: "That'll do: tha can go whome now." An ah were that glad it were all over an done wi' that ah picked up hat an coat—an walked straight into British Army.

It were hearin last little bit that tore it. Her looked sawny, but her were Specialist reet enough.

F. HEATHERLEY.

Junior Guyite Club.

The 36th Dinner of the Junior Guyite Club was held at the Restaurant Frascati on May 18th. The following members were present:—

S. E. Prall (President), P. N. Randall (Vice-President), H. G. Ashwell, F. Beard, H. Blatherwick, T. Brown, F. F. Burghard, H. E. Councell, P. J. Curtis, J. A. Fraser (Hon. Sec.), V. Glendining, E. W. Goodall, G. W. Goodhart, J. W. F. Jewell, N. E. Kendall, T. B. Layton, G. Marshall, R. A. Milligan, R. Oram, J. G. P. Phillips, A. E. Price, C. E. Price, R. M. H. Randell, R. P. Rowlands, R. J. Ryle, F. D. Saner, A. H. Tubby, P. Turner and A. M. Zamora.

L. Bromley, D. J. O'Meara, and J. A. Currie were present as guests.

The following members had accepted, but were prevented from attending:—R. Davies-Colley, J. W. H. Eyre, C. H. Fagge, H. French, V. E. Lloyd, W. M. Mollison and A. R. Thompson.

The following members were duly elected:—L. Bromley, A. H. Harkness, R. B. P. Lansdown, G. J. Mullally, R. G. Oram, J. F. Robinson and J. A. Ryle.

The Dinner for 1923 was fixed for the second or third Thursday in May, the choice between these dates being left to the discretion of the Secretary, and it was again decided to secure the Alpha Salon at the Restaurant Frascati.

The vocal and instrumental music (professional) arranged by Dr. J. G. P. Phillips provided those present with an excellent evening's entertainment.

At the conclusion of the evening the President thanked Dr. Phillips on behalf of the Club for securing the services of the performers.

Change of Address.

Erskine Faraker, M.R.C.S., L.R.C.P., Medical Officer, U.F.C. Mission Hospital, Kalna, Burdwan District, Bengal.

M. H. Thornely, Lt.-Col. I.M.S. (retired), 21, Alexandra Road, Epsom.

When the "Gazette" was Young.

(*Continued*).

RICHARD PARTRIDGE.

I remember being examined at the College, the year before the GAZETTE appeared, by Partridge, who was surgeon to King's College Hospital in Portugal Street. He was a man just then of European fame, for it was he who was selected to go over to examine the foot of the great Garibaldi, who had been wounded in the foot during the long guerilla warfare, in which he was so long and eminently engaged. The wound kept open and it was suggested that the bullet still remained in the foot. Partridge was required to express an opinion definitely on this point. He came to the conclusion that there was no bullet in the foot, and that in time the wound would heal without operation. However, it showed no disposition to heal, so France was asked to examine the wound. She sent over a probe with an unglazed porcelain tip, which revealed the presence of a bullet by bringing up from its exploratory use marks and rubbings of lead.

Specially invented for use on Garibaldi, this porcelain tipped probe has ever since borne the name of its inventor. I remember distinctly how the whole profession in England shared with Partridge the humility of occupying second place, when France, in the eyes of all Europe, so clearly took the front seat.

Partridge was a short, square-built little man who leaned his head sideways over his shoulder and looked at candidates out of the other corners of his eyes. The first time he "took" me at *viva voce* he made me so self-conscious that I had difficulty in recalling even the names of well-known bones.

A GENIAL EXAMINER AND A GUY'S PET.

His colleague Edward Cock, then Senior Surgeon to Guy's, came up and smiling, patted me on the back, and said, "T-take your t-time, I k-know you know it as well as I do." This at once gave me courage, and my nervousness went.

What a favourite Cock was at Guy's! How all the students loved him! He made it a point always to preside at the first meeting of the Physical Society each Winter Sesion. When he rose to speak, what prolonged cheering there was! It seemed always as though it would never cease. But when at last, he found opportunity to speak, his voice trembled with emotion as he commenced. "Gentlemen, it m-m-m-makes m-my old heart young again to come among you once m-more." He was indeed a lovable old man, and the inventor of the operation which bears his name.

Mr. Cock often used to come to the Hospital and look round, after his retirement from the active staff. I remember that on one of these days, when he sat in the theatre looking on at the operations, Mr. Durham happened to have two cases in which he proposed to to drain the bladder through the perineum by means of "Cock's operation." These two cases came into the theatre consecutively, one sharp on the heels of the other. Both of them were done with Mr. Durham's usual skill and celerity, and as he rose from the stool after the second one, he found Mr. Cock standing close behind him at his elbow. "Now Mr. Cock," he said, "I hope you don't feel ashamed of your pupil?" "N-N-No!" said Mr. Cock emphatically, as he took an extra pinch of snuff, a sure sign of the sincerity of his words. The situation was dramatic.

COCK'S OPERATION

Is one of the prettiest and must useful operations there are. I have heard it said, that it is never performed outside Guy's. That is not correct. But whether it is ever done except by Guy's men, is more than I can say. In an experience of nearly sixty years I have seen it done only by Guy's men. It is so sure and certain, and quick, that all other methods of overcoming an impassable stricture are most tedious and dangerous. The only modification I make is, that I turn the edge of the scalpel upwards. This admits of the back of the blade being firmly pressed against the pulp of the left index finger, and an accurate position being secured in the prostatic groove. It is best to divide skin of the perineum with a moderately free preliminary incision and then complete the operation in one more single incision.

I have heard Cock say, as he emphasised it being done in one straight deep cut, "Gentlemen, if you once take your knife out, you never need put it in again." It is a neat,

clean and successful operation, and one worthy of the name of its beloved inventor. I have often heard surgeons giving elaborate reasons why they preferred other methods, but in my own mind, I have felt the one true reason to be they they *dare* not attempt it.

Teaching and Text-Books.

If a student who had just finished his curriculum were to go back from "now" to "then" he would find a very great difference in the way in which surgery was taught. The lecturers and examiners then were mostly old men, men who had been educated before the anæsthetics had totally changed the technique of the theatre. There was still a great deal of the "cut and dried" operation. Everything was classified and reduced to a system.

Dogmatism of the Past.

Supposing an amputation on some part of the lower limb had to be done. It was definitely decided whether it was to be a Syme or a Chopart or a Pirogoff. The student had to learn what were the respective advantages of each one of these, in what one was superior to the other, and when and why he would prefer each.

He was taught to be clever with his hands, and perform the several steps of the operation *secundum artem*. In amputation about the hip-joint he learnt certain definite lines, and used instruments of a certain shape and size. At an examination he had to select his instruments from a collection, and the examiner criticised his choice. Certain routes required certain shaped knives of a certain length. There must be no attempt at originality. I do not know what would have been said to a man who chose for an amputation at the hip-joint, a short strong scalpel with a blade only 2 inches long, which is really much more convenient and handy than the old long straight blade about 16 or 18 inches long, long enough to transfix the buttock. Slowly all these "set" forms are falling into disuse.

Surgery of the Peritoneum.

Another striking change is the veneration and respect in which the peritoneum used to be held. So long as perfect cleanliness is observed, a surgeon now would as soon operate on the peritoneum as on the skin. Then it was taboo and must never be opened, exposed or touched except when life itself was almost at stake.

It was regarded as a tissue which had a most uncertain temper. At one time it would show no resentment; at another, even the least interference with its sacred precincts would be followed by the most intense peritonitis; so it was best left alone except in the direst necessity. In the operation for the relief of a strangulated hernia some surgeons would never open the sac, if the gut could be got back without; others would open it under certain conditions only.

I regret that I have none of my old books on surgery left; it would have interested you for me to quote some passages. The subject, "When to open, or not to open the sac in operating for strangulated hernia," was a fine subject for an academical discussion, and at professional gatherings leading operators would show their erudition and experience by the refinement of their reasons *pro* and *con*.

As I have said, the great authority in those days on hernia was John Birkett, and he used in his clinicals to discuss this subject over and over again, impressing on the students the gravity of the issue, the responsibility that rested on the operator in opening or not opening the sac. But the question must be met, for on the one hand, if the sac were not opened, he might reduce a gangrenous knuckle of intestine, or even adhesions which would keep up, if not the strangulation, at least the obstruction, thus rendering the operation ineffectual. On the other hand, if the sac were opened as a routine measure, undoubtedly there would be a percentage of unnecessary deaths. So the conditions demanding an opened sac must be laid down on definite lines so that each operator might realise his position. These were the conditions which at Guy's called for an inspection of the contents of the hernial pouch—if the taxis had been very violent or prolonged; if the contents could not be reduced alone, that is, the sac emptied; if the patient's condition suggested gangrene or other complication, for epiploceles often introduced danger, such as the formation of a secondary "internal" adhesion, in addition to the primary "external" grip by the pillars of the ring.

These, I remember, were the three great facts on which a surgeon was justified in taking such a serious step.

This is a good type of the dogmatic, precise lines which were laid down, and the knowledge

of which was considered by the examiners as a knowledge of surgery. Now, we know the real conditions on which sepsis depends, and would as soon think of employing "violent taxis" as cutting it off, and as for "opening the sac," it is a radical necessity which lies at the root of the successful treatment of an irreducible hernia. Nothing could better illustrate the difference between the "science" of surgery which the GAZETTE was born to and the radical truth of the "principles" which it so nobly expounds to-day. One is the dogmatic definite teaching of a narrow ignorance, the other is the broad clear light of Truth, by which each may see for himself and recognise his exact duty.

I remember distinctly, and the infancy of the GAZETTE was not over, when patients with acute intestinal obstruction were allowed to die, rather than open the peritoneum. I have stood beside beds where the peristalsis could be plainly seen through the abdominal wall, which together with the fæcal vomiting was shown to the students as conclusive proof of complete obstruction, and yet the knife was not resorted to.

In these days when forcible taxis is looked on as an injustice to any ruptured person, and an unopened sac is the mark of an unfit operator, when the visible peristalsis is direct evidence of the gross neglect of somebody, and fæcal vomiting almosts warrants an action for malpraxis, it is strange and weird to think of the above being discussed gravely by our leading surgeons.

CLASSIFICATION AND PRECISION.

The same prevalence of the "science and art" of surgery being, as it were, crystallised into definite classes and classifications, was seen in the division of burns into six groups, extending from the mere redness and superficial dermatitis of the *first* degree to where the whole thickness of the tissue sloughs and becomes necrosed in the sixth degree.

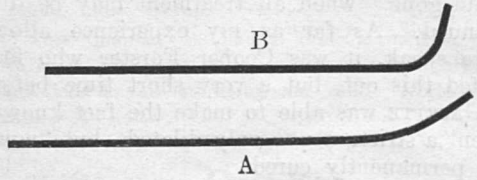
ALFRED POLAND.

I once had a syllabus of the "Lectures on Surgery" by Poland, when he was lecturer on the subject. Everything was classified and grouped in strict order and sequence, showing ascending and descending changes in the scale. It was like a chapter in Cuvier or Linnæus—there was no room for variation. It was all laid down precisely; so was the treatment. Divisions now are more for convenience of description and identification, rather than indicative of a definite difference.

Poland left Guy's at about the same time, roughly speaking, as the GAZETTE entered it. I did not see very much of him as a surgeon, but I remember one great reputation he had, that is, as far as my experience of him extends, his dressers could never get him a case of urethral stricture so tight that he could not get a catheter through. After these long years it is impossible for me to say I never saw him *once* resort to urethrotomy, it would be saying more than I remember; but his dressers used to say he could get a catheter through every case, however tight.

THE "LITTLE PERSUADER."

There were plenty which they themselves could not manage, and which they fondly hoped would also "stump" him, but he used to smile and draw from the inside breast pocket of his coat what he called his "little persuader." It was a very fine, short, silver catheter, not more than eight inches long in a straight line, and of a much slighter curve than the usual pattern. The curve, instead of being about one-fourth of a circle, was about one-sixth—a short catheter with a long curve, vide sketch A, quite a contrast to the usual right angular curve B.



After his death Millikin (predecessor of Down) bought the instrument and took the pattern in silver and plate and sold me the original. I found it as good as its reputation, for it could be passed in the tightest stricture and I don't remember ever having to do an external urethrotomy afterwards in any case which was uncomplicated by other things, such as external violence, suppuration, rupture of urethra, etc., in other words in any stricture the result of chronic urethritis. No doubt Down's, even now, could make the exact shape. In unskilled hands it is a dangerous weapon; but to anyone accustomed to its use, it sometimes seems quite uncanny in the way it glides through the rocky parts. Then usually after

the contracted portion had been rested for a week by the gentle use of this, and a rubber catheter, there would be no difficulty in dilating by the ordinary method.

Methods of Urethral Dilatation.

While on this subject I would say that it was probably only a very short time before the appearance of the Gazette, that Cooper Forster instituted the practice of dilating all his strictures up to No. 16 instead of No. 12. It was found that No. 12 did not fully dilate the canal. Its maximum size is 16. This was found to be a radical change of the highest importance. When the bulbous sounds were first introduced, the object of the terminal enlargement was not generally appreciated, and I have frequently heard it said, "I don't see what use this knob is, the sound would be better without it." But, as everyone knows now, it is the bulbous end which gives the surgeon the very knowledge he is seeking, and which the plain dilating sound cannot indicate. That is, when the stricture is really "cured," or only "fully dilated."

A stricture may be fully dilated, so that a No. 16 passes easily, but it will gradually contract again, if the treatment be discontinued. The bulbous end is the indicator which to the surgeon skilled in its use, shows the difference between this stage, and the time of "quite gone," when all treatment may be discontinued. As far as my experience allows me to speak, it was Cooper Forster who first pointed this out, but a very short time before the Gazette was able to make the fact known. "Then" a stricture was only dilated, but "now" it is permanently cured.

The Position of the "Gazette."

I think the position of the Gazette in its first three or four years was very similar to the present state of the Clubs' Union. It was held to be an excellent thing and one which must on no account be allowed to drop, as its success interested everybody. This was the sentiment and feeling of by far the most powerful majority, but the practical part was equally important, men would not give their time to it. They read it with avidity, but they would not write for it. Some said they had no time; some said they had nothing to say. Some promised they would write something and then forgot their promise. One, having promised, would forthwith be in a fever heat of excitement and mental tension until it was all over, in the meantime sending me a syllabus of what would be the headings of their article. I was greatly amused. He was a most worthy man, who tried to live to the utmost of his powers a perfect life. He would do anything for anybody, whether he was a friend or not, if he felt it his duty to do so. His last thought was his own vanity or glory. The composite picture thus presented was most comical, yet we could not but admire him.

This syllabus alone would have filled a column, but I fear the completed essay would have monopolised a year's issue. What I asked men to give me was a note, long or short, of what they saw, or heard, or did; just write it simply down on a bit of paper and send it to me and I would see to the rest. Oh! no, they could never write anything worth reading. Then tell me and I will write it. It was no good; they were shy and dared not face the criticism of print.

Between these two classes—those who would have taken an enormous amount of pains, or none at all, and those who would take none—the poor, half-starved Gazette nearly perished, but it had a small band of faithful friends who made up for any deficiencies and saved its life. Among these was Dr. Moxon who often sent in his philosophical scraps on a bit of paper above the signature of "Pilocereus Senilis." Another contributor later parodied this by signing himself "Pilula Ceruleus," a blunder quite an accident (for he knew better) which gave rise to much merriment. Indeed, some asked if the Gazette was inviting the contributions of comic writers. Dr. Owen Rees occasionally sent us cheerful words. He used to beg of us to enlarge the column which tabulated briefly the cases admitted during the week. He said that this column alone was most important and interesting. It was, however, a difficult column to compile correctly and keep up to date. There were too many blanks. Some could only be filled in by Post-Mortem Records. We tried to keep it properly filled in but for the labour required per line, it was the most expensive news in the Gazette. Each case took one line. Each ward was taken in turn. First was the date, then the number of the bed, then the diagnosis, or ?.

It might have been worked better from the Office, but it was very unedifying to read in

this column that in Ward Nicholas, No. 8 bed a case of "hæmorrhoids" had been admitted on the 7th inst., and in another column would be found an account of "a post-mortem on a case of Intestinal Cancer," or to see the death of a patient from "obstruction of the bowels" in one part of the journal and in another an excellent description by a P.M. Clerk of the discovery of long slender fibrous band constricting the ileum, and how the Morbid Anatomy Demonstrator divided it with the point of his knife and said: "Twenty-four hours ago, gentlemen, this would have saved the patient's life." The P.M. room has well been called by some "The Room of Humiliation."

(*To be continued.*)

Reviews.

The Venereal Clinic.—By Several Writers. Edited by Ernest R. T. Clarkson, M.A.Cantab., M.R.C.S., L.R.C.P. (Messrs. John Bale, Sons and Danielsson, Ltd. 1922.) Price 25s.

This excellent manual deals with venereal diseases from both the medical and sociological aspect. The title is appropriate, inasmuch as the volume will be found most useful and practical by all workers in venereal clinics.

Throughout the book, the various sections and chapters combine clearness and brevity, and for both reasons should be especially welcome to students.

Syphilis is dealt with by Mr. Malcolm Simpson and Dr. Semon, the various stages and diagnostic methods being well described. The cutaneous lesions are well described and thoroughly discussed and are accompanied by some useful plates.

The differential diagnosis of the faucial lesions could have been more full, no mention being made of Vincent's Angina or Diphtheria.

Methods of treatment are explained in detail, but some readers would prefer to give longer courses of arsenical preparations.

Gonorrhœa is dealt with at length in an essentially practical manner. A useful chapter on Anatomy precedes a thoroughly practical section on the diagnosis and treatment of the various phases of Gonorrhœa and its complications.

Well merited attention is drawn, not only to the prostate and seminal vesicles, but also to the ampulla of the vas deferens, as lurking places of the gonococcus, and to the necessity of their thorough examination in all cases of rheumatism and initis, and in all apparently cured cases.

The statement that normal seminal vesicles cannot be felt per rectum, must not be accepted without qualification, since normal vesicles distended with their normal contents can be frequently palpated. Of methods of treatment, irrigation is preferred and vaccines are not greatly relied upon.

With regard to the diagnosis, in cases of posterior urethritis (excluding cystitis, pyelitis, etc.) by anterior irrigation and subsequent urinary examination, many observers would not accept the dictum that a purulent urine coming from the posterior urethra necessarily indicates a prostatis.

The section on the urethroscope by Mr. Wyndham Powell, which contains some unrivalled plates, is extremely valuable, and should be carefully studied by all who are desirous of becoming expert in urethroscopy.

The diagnosis and treatment of gonorrhœa in the female, with their attendant difficulties are briefly but clearly discussed by Miss Rawlins.

There is a useful chapter on laboratory diagnostic methods and bacteriology, by Dr. Paton, in which a new modification (Donald's) of Gram's method is recommended.

Secondary infections of the urethra and accessory glands receive scant attention, although the majority of old chronic gleets are kept up by micro-organisms other than the gonococcus.

Part II. discusses the prevalence and incidence of venereal diseases and their high rank in the mortality rate.

The constitution, aims and methods of the N.C.C.V.D. and the S.P.V.D. are clearly presented, and the references to existing legislation will be found most useful.

This manual is handy and attractive, is well printed and illustrated and can be highly recommended to all students and clinic workers.

Cricket.

GUY'S v. BROMLEY.

Played at Bromley, Saturday, May 6th.

Saint and Harris started batting for us. Saint played well until he got out. Harris has a very pretty style, but not enough scoring strokes; he fields well, and with a little more enterprise when batting, he should make a very useful cricketer. When Wooldridge went in, things were not going too well. However, he soon told us he would make some runs; while getting the runs, as promised, he tried to drive a ball. Somehow or other one of the screws must have dropped out of his bat, for as he hit the ball, his bat split right *across*. On examining the mass of débris afterwards, we decided

it was of uncertain date and make, but most probably a "Nattibumpo" which had been kept in cold storage since the Coronation. We had another bat with us, however, and he carried on with that. Van Schalkwijk assisted him, and together they kept the scorers busy. There can be nothing wrong with Van Schalkwijk's eye, for from the moment he went in until the moment that Wooldridge declared, he was either hitting them hard, just out of long-on's reach, or sending them past point's head like meteors. One of his star turns.

Our declaration left them with about the same time that we had taken to make the runs. At first they looked as if they were trying to get them, but when their first few batsmen were out, including Whiteoak-Cooper who batted so well against us last year, the remainder thought it would be better to make a draw of it. We thought that we ought to win it; we did, but with only five minutes to spare. This shows an interesting situation and some differences of opinion which can arise from a game of cricket.

Van Schalkwijk never found his length properly, at first pitching them just behind the well-padded Crisp. Out other bowlers did well. Like the curate's egg, our fielding was quite good in parts.

Guy's.

H. A. H. Harris, run out	12
N. H. Saint, c White b Stone	16
L. B. Helder, b Shepherd	7
T. Wooldridge, not out	82
J. Van Schalkwijk, not out	58
Extras	35
Total (innings declared)	210

Did not bat: G. L. Shearar, A. G. Ensor, F. J. Biddle, E. J. Crisp, G. W. Rees, H. B. Cahill.

Bromley.

F. O. Grant, c Shearar b Saint	28
F. L. Moore, c Shearar b Saint	10
J. J. Frazer, c and b Saint	4
F. C. Speed, b Wooldridge	31
P. Whiteoak-Cooper, b Wooldridge	30
H. G. Hatcher, b Wooldridge	0
L. J. Eames, b Biddle	7
Shepherd, c Wooldridge b Biddle	10
Whyte, c Helder b Biddle	12
L. V. Stone, not out	31
Brooks, lbw b Wooldridge	2
Extras	11
Total	176

Bowling:—N. H. Saint, 3 for 58; F. J. Biddle, 3 for 39; J. Van Schalkwijk, 0 for 22; T. Wooldridge, 4 for 48.

GUY'S v. CATFORD WANDERERS.

Played at Honor Oak Park on Wednesday, May 10th.

We won this, our first home match; there were no sensational scores. Catford won the toss and elected to bat first (I got this from a newspaper). Of course, our job was to get them out for as few runs as possible. So after Saint and Van Schalkwijk had each taken two wickets, Biddle was put on; this for the uninformed:—Biddle now bowls a ball which turns from the leg and sometimes stands up against the batsman so that he cannot refrain, without great inconvenience to himself, from striking it into the air. Owing to the accurate placing of the field, the ball travels direct to a fieldsman, who, by hugging it to his body before it bounces, causes the striker to be "out." Five for nine! Phew! (This is not an echo of Billingsgate on a Saturday night, it's Biddle's average). It may be noted with interest by some that one of their men was "not out": this was not due to an oversight on our part.

Our batting did not show to great advantage, although their bowling was not strong. Shaw and Saint must be exonerated from all blame, and, I suppose Wooldridge, too, for there's no knowing what he might have done. The rest of us formed a young procession and followed one another in, and out, at regular intervals.

Catford Wanderers.

J. Cleeve, st Crisp b Saint	11
V. Wood, c Hutchinson b Saint	5
Henderson, b Van Schalkwijk	3
C. Lawrence, b Van Schalkwijk	0
W. Lawrence, c Hutchinson b Biddle	11
Langford, c Ensor b Biddle	22
Baker, c Ensor b Biddle	0
Hopkins, c Ensor b Biddle	4
Nicholls, b Rees	1
Edge, c Rees b Biddle	1
Miller, not out	0
Extras	1
Total	59

Bowling:—J. Van Schalkwijk, 2 for 22; N. H. Saint, 2 for 16; T. Wooldridge, 0 for 10; F. J. Biddle, 5 for 9; G. W. Rees, 1 for1.

Guy's.

G. D. Shaw, b Miller	17
N. H. Saint, lbw b Henderson	32
F. G. Hutchinson, b Miller	13
S. R. Trick, b Henderson	8
A. G. Ensor, lbw b Henderson	0
J. G. Van Schalkwijk, b Lawrence	0
T. Wooldridge, not out	2
E. J. Crisp, b Henderson	6
G. W. Rees, b Henderson	0
F. J. Biddle, c Baker b Lawrence	0
P. G. Harvey, b Lawrence	0
Extras	3
Total	81

GUY'S v. SEVENOAKS VINE.

Played at Sevenoaks on Saturday, May 13th.

Shaw was run out in the first over and Helder was bowled soon after. Saint was in for some time and made some very nice shots. The best thing of the day was Wooldridge's innings. 152 runs take some getting, and he got them by really good cricket; he made the bowling seem too easy, by hitting freely all round the wicket and not giving a single chance.

Isaacs played a useful innings. He went in to bat firmly convinced that he would give nothing away—especially not his wicket. For a good half-hour he annoyed the bowlers by gently returning to them the balls which they had hurled at him. He undoubtedly made things easier for Wooldridge.

Van Schalkwijk bowled well, taking two of his wickets with real "fizzers." Biddle seemed very troublesome to some of the batsmen, so that they again struck the ball into the air and got caught. The little fielding that we had was done fairly well, but we must not shout about it.

Although the sun shone every now and then, it was the sort of day that the ice-cream man would take off for his round of golf. The only people who seemed to be decently warm were Wooldridge and the Sevenoaks' bowlers.

Guy's.

N. H. Saint, hit wicket b Wells	19
G. D. Shaw, run out	0
L. B. Helder, b Wells	3
A. Isaacs, b Grose	13
T. Wooldridge, not out	152
J. Van Schalkwijk, not out	18
Extras	28
Total (innings declared)	233

Did not bat: A. G. Ensor, F. J. Biddle, C. Arkles, J. C. Hewetson, E. J. Crisp.

Sevenoaks Vine.

H. J. Taylor, b Van Schalkwijk	0
A. M. Sayers, b Van Schalkwijk	1
H. Thompson, c Shaw b Van Schalkwijk ...	21
T. A. Grose, b Van Schalkwijk	8
J. M. Dubuison, c and b Biddle	19
A. Loney, b Van Schalkwijk	16
T. K. Essinhigh, c Arkles b Biddle	8
H. M. Sayers, b Van Schalkwijk	7
A. C. Norwood, not out	3
H. Fuggle, c Arkles b Biddle	0
S. W. Wells, c Arkles b Biddle	4
Extras	12
Total	99

Bowling:—J. Van Schalkwijk, 6 for 43; N. H. Saint, 0 for 25; F. J. Biddle, 4 for 19.

GUY'S v. HONOR OAK.

Played at H.O.P. on Saturday, May 20th.

On a hot day, and before a large crowd, we started batting, at least Saint and Shaw did for us. I say "started" advisedly, for Shaw was soon caught in the slips off a ball which turned in, kicked, and threatened to hit him just where the dress-shirt stud goes—nasty thing—and Saint was only just beginning, when he received such a corker from Gibson, who was bowling really well and mixing them up cleverly, that he came out to see how the game was going. We would like to see these two make a lot of runs together, for we know that they can both bat. Helder was billed to appear next and he gave us quite a good turn; he got several runs from that quaint little shot of his through the slips. Arkles showed promise, but he got a good one from Lockton. After making several beautiful shots, Wooldridge hit one with his leg instead of with his bat. So he has at last got an average. It is only 263, but with the assurance of one of our daily newspapers that within a short time it could procure indisputable evidence that at least seven boys had each done the same thing, or better, while still at school, we hope he will feel easier about it and raise it to the 300's. When approaching the wicket to deliver a ball, Lockton had to cross the rugger field, and on alighting from one of his periodical leaps he jarred his leg on some hard object—perhaps a pelvis left here by a Coventry man last term. It was bad luck on him and his side; we did not mind him not bowling, for in 1920 he took all our ten wickets for an average of 5 runs per wicket.

O'Gorman was bowling some slow stuff which a batsman can so easily make appear difficult; he got his wickets alright, though. Our tail seems to be suffering from paralysis, or some kindred disease, for at two attempts now to stimulate, there has been absolutely no response.

Our bowling was quite good throughout; our fielding amazing. Arkles showed up well here, for he always chased the ball with hare-like rapidity, and stopped those within reach. Towards the end Wooldridge bowled very well; he is a finger-spinner who bowls with his head. He knows when, and where, he has got the batsman beaten; he also knows when the batsman has got him beaten (the fielders have to know where).

While all this was happening, we were getting excited. It was only natural, for they were getting nearer our precious 94 and their wickets were falling gradually. After Abel was out, 7 for 70, Thorpe had added a few runs, when he suddenly hit the ball well and truly into the air, after the fashion of a Jersey cow. Van Schalkwijk saw it coming from afar off and seized both opportunity and ball. 8 for 82, O'Gorman then came in and played steadily,

and just before Lockton was bowled, he managed to beat us. A few balls after this he was out himself. A finish like this is of the sort we like; it is one of the many things that make cricket a game worth playing.

Guy's.

N. H. Saint, b Gibson	3
G. D. Shaw, c Cook b Gibson	2
L. B. Helder c Lockton b O'Gorman, J. ...	36
A. C. Arkles, b Lockton	4
T. Wooldridge, lbw b Abel	27
J. G. Van Schalkwijk, b O'Gorman	1
G. L. Shearar, b Abel	6
A. G. Ensor, not out	0
L. S. Williams, b O'Gorman, J.	0
F. J. Biddle, lbw b O'Gorman, J.	0
E. J. Crisp, c Gibson b O'Gorman, J.	0
Extras	15
Total	94

Honor Oak.

W. T. Cook, b Van Schalkwijk	14
W. A. Pearce, b Saint	1
C. Wise, b Van Schalkwijk	1
D. O'Gorman, lbw b Wooldridge	23
R. C. Alwin, b Shaw	11
C. M. Campbell, c Saint b Wooldridge ...	11
G. A. Abel, c Van Schalkwijk b Shaw ...	0
A. R. Thorpe, c Van Schalkwijk b Wooldridge	10
J. O'Gorman, lbw b Wooldridge...	11
J. H. Lockton, b Wooldridge	4
C. Gibson, not out	1
Extras	9
Total	96

Bowling:—Van Schalkwijk, 2 for 27; Saint, 1 for 20; Shaw, 2 for 24; Wooldridge, 5 for 16.

Tennis.

On Saturday, May 6th, the first match of the season was played at Honor Oak Park. The 1st team—Jackson, Nesser, Nurick, Schollum, Lewis-Philipps and Schlimmer—played the Gallery L.T.C., and after a hard fought game, in which one set ran to 30 games, lost. Jackson and Neser, and Philipps and Schollum each won one set.

The first team—Jackson, Neser, Nurick, Badenhorst, Gordon and Patts—played Ruskin Manor at Honor Oak Park on Saturday, 13th. The only couple to win a match being Jackson and Neser. Many of the games were only won by a very narrow margin, which reflects creditably on the team, as Ruskin Manor is one of the strongest teams in Surrey.

The following representing the Hospital in the Junior Competitions of the Surrey L.T. Association's Summer Competition won an easy victory over the Mansel L.T.C. on Saturday, May 13, at Honor Oak Park, Schollum, Lewis-Philipps, Schlimmer and Becker.

Golf.

STAFF v. STUDENTS.

The Annual Match between the Staff and Students was played over the Course of the West Kent Golf Club, Chistlehurst, on Wednesday, May 17th, and resulted in a win for the Staff by 1 match as shown below:

Staff.		Students.	
Mr. Bromley (7 & 6)	1	K. Hooper	0
Dr. Cameron (2 & 1)	1	L. W. Cann	0
Dr. Hunt (7 & 6)	1	D. B. Whitlock	0
Mr. Mollison (5 & 3)	1	T, A. Shaw	0
Mr. Scott	½	H. Moore	½
Dr. Ryffel	0	C. W. Greenway (3 & 2)	1
Mr. Malleson	0	D. G. Bawn (4 & 3)	1
Mr. Chapple	½	F. James	½
Prof. Johnstone (1 up)	1	F. W. Schofield	0
Mr. Hughes	0	J. P. Evans (3 & 2)	1
Mr. Davies-Colley	0	E. F. Graham-Bonnalie (5 & 3)	1
Mr. R. Hughes (1 up)	1	G. D. Shaw	0
Mr. Fox	0	G. W. Gathergood (4 & 3)	1
	7		6

Publications Received.

British Medical Journal, The Isis, The Old Cambridge, The New Cambridge, The Northampton Gazette, The Indian Medical Record, Archives of Medical Hydrology, Abstracts of Bacteriology, The Queen's Medical Magazine (Birmingham), The Hospital Gazette.

Birth.

COCKS.—On Easter Day, April 16th, 1922, at Knapsdale, Brown's Town, St. Ann, Jamaica, the wife of Gilbert Anderson Cocks (née G. M. Shaw-Allen), of a son—Peter.

Marriage.

WILLIAMS—STANSFELD.—On May 11th, 1922, at St. Peters, Berkhamsted, by the Rev. John Stansfeld (uncle of the bride), Ronald Edward Williams to Winifred Marguerite Stansfeld.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

VOL. XXXVI, No. 885.] JUNE 10, 1922. [NINEPENCE.

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Passim.

THE Derby, having stirred our Hospital existence to its depths, has departed, and left us more or less as we were before. Those of us who have not drawn the winner in sweepstakes are not disposed to grumble, even though it has never come our way to draw a horse, and we are assured by one who went on the Residents' Bus to Epsom, that the unspeakable Sid. Jarvis was not there, although a few other gentlemen appeared desirous of succeeding him in his rôle of welsher.

From the point of view of the general public, this was said to be the most brilliant Derby on record. From the Hospitals' point of view, we believe that a similar success may be claimed, although details of the amounts collected are not yet to hand. A letter from the Secretary of the Hospitals' Appeal Committee thanking students for their assistance and co-operation will be found in the Colonnade. The letter expresses the hope that students found a "certain enjoyment" in their labours. This we cannot doubt.

The other great organised collection — the Empire Flag Day—was productive of £40,000, £1,518 17s. 11d. of which was collected by Guy's students and nurses. The average for this Flag Day came to £2 per box, while the average on previous occasions has usually been about half this amount. It will be seen that Guy's and the Borough played no mean part in the day's work.

Details of the remaining events in the Hospital Campaign will be found on the notice-board in the Colonnade.

THE passage through Maze Pond and St. Thomas's Street on Sunday, May 28th, of a hilarious band dressed in the most variegated colours, and unwontedly tuneful even for denizens of the Borough, may have caused some tired healer of the sick to look at the cavalcade with concern and astonishment. But his concern will vanish, though his astonishment will perhaps increase, when he hears that these gay people collected £396 18s. 3d. for the Hospitals on that Sunday. The collection is organised annually by the South Eastern Hospitals Demonstration Committee. The previous year's collection amounted to £396 5s. 1d.. Our friends deserve our grateful thanks.

DR. LAIDLAW was the guest of honour at a dinner attended by members of the Senior and Junior Staff on Wednesday, May 24th. We have, in a previous issue, given expression to the regret which his departure has inspired

in all at the Hospital. His absence will be widely felt, most of all by those who were intimately associated with him in his work.

It will be seen, on consulting the notice on page 240, that it is proposed to institute a new prize, known as the Laidlaw Prize, for the best paper upon a pathological subject read before the Physical Society.

It is desired to collect the sum of £100 for this purpose. Of this, £40 has already been promised. It is fitting that some permanent memorial to the affection and esteem with which Dr. Laidlaw is regarded should be established. We do not think that anything could be more fitting than to commemorate his association with the Physical Society by the establishment of such a prize. Everyone should contribute something, however insignificant the amount may seem, towards the fund, and so do honour to a valued teacher and friend.

Another Dinner which has recently taken place is the Staff Dinner, to which Governors of the Hospital and Members of the Staff are invited. The Dinner took place on June 7th at Oddenino's Restaurant—which seems to be a favourite haunt of Guy's diners—and we hear that it was very well attended and a great success.

It is gratifying to reflect that the inclusion of a famous bonesetter's name in the Birthday Honours List has so closely followed an appeal made on his behalf by Sir Arbuthnot Lane, Sir Alfred Fripp, Sir William Morris, and other distinguished members of the profession. Whatever views are held upon the subject of unqualified practitioners, no one can cavil at the honour done to so devoted and skilful a worker as Sir Herbert Barker.

At the time when the memorial on his behalf was first sent to the Prime Minister, we commented on the advantages of conferring some honour, other than a degree, upon the distinguished manipulative surgeon. An honour of this kind is a fitting recognition of the labours of such a man. To confer a degree upon him would be to establish a precedent whereby a man could obtain a qualification without working for it as he should, and other unqualified men, less skilful than Sir Herbert Barker, might gain admission to a profession, membership of which should always be dependent upon ability.

The public are protected, to some extent, by legislative measures from the onslaughts of those who practise medicine or surgery without a qualification, and the dental profession also is coming into line in this respect.

No action can be contemplated, therefore, which would tend to diminish the confidence of patients in the efficacy of a registrable qualification as an indication of training and knowledge.

But we are glad that the ancient spirit of prejudice has been so exorcised that surgeons of reputation can now recognise ability in an unqualified colleague when they see it—a condition of affairs which, it is no libel to say, did not exist thirty years ago.

The date of publication of this issue is also the day of the Inter-Hospital Sports. We have already referred to the inclusion of this event in the campaign of the Hospitals Appeal Committee. Good sport should be witnessed with such athletes competing as C. L. Steyn, who recently beat the English sprint champion; H. Stallard, the miler, who broke the British record last year in the A.A.A. Championships; J. C. Ainsworth-Davies, the Olympic Games quarter-miler; and R. C. Lightwood the International miler. We are assured in addition, by the secretary, that there are some very fine coming athletes from Guy's! Tickets may be obtained at the gate to-day. The prizes will be presented by H.H. Princess Marie Louise. Some of the events have taken place already. We hear that L. G. Housden ran a very fine race against Lightwood in the three

miles, securing second place for the Hospital after a close race.

THE Secretary of the Swimming Club asks us to draw attention to the United Hospitals' Swimming Gala, which will take place at the Bath Club on Wednesday, June 28th.

Last year's Gala was an unqualified success, many people being refused tickets, and it is anticipated that this year an even better evening's sport will be provided.

The Hon. Secretary of the Swimming Club is anxious to obtain as many entries as possible for the open events, and he also desires Hospital support at the finals of the Diving, Swimming and Water Polo Cups, all of which we won last year.

Those who went to the Bath Club last year know what an excellent show it was. They should tell their friends, and ensure a similar success this year.

THE Mixed Doubles Tennis Tournament, which took place on Whit Monday, was a great success from every point of view. We feel sure that we are but voicing the general opinion when we congratulate the Tennis Secretary upon the excellence of the arrangements.

We shall hope to see other similar tournaments in the future. Nurses and students do not often have an opportunity to partner one another in games, but there is no doubt that such a partnership does good, oiling the wheels of hospital work in a manner which few find unattractive. Even the slight (and natural) peevishness of those who are unable to get away is fully compensated by the general good done by such a tournament.

THE Boat Race against Bart.'s will take place on June 14th at 5 o'clock. We advise the affluent to spend three shillings on a seat in the launch, details of which will be found on page 256. It would be a pleasant innovation if other supporters were to arm themselves with revolvers, after the manner of undergraduates during eights' week at Oxford. Revolver practice on the tow path would help materially in furthering the objects of the Brighter London Society.

THE results of the Final F.R.C.S. Examination reveal another triumph for Guy's. We hope that the Primary Fellowship candidates will be as successful. Our congratulations are due to Messrs. Carter-Braine, Gaymer-Jones, Massie, Medlock, and Victory upon their success, and to those responsible for the course held at Guy's, upon the high percentage of passes.

IT seldom happens that we are without some cause for complaint. On this occasion our plaint is purely Editorial. It concerns the callous indifference of reviewers to the agonies undergone by Editors when reviews of books are not forthcoming. What *is* the use of a review of a book which has already reached a further edition? It should not be such a great effort to review a book after three months' perusal of it, and we must ask each of our reviewers to sit down and write one of his thoughtful analyses—*stat.!*

The Empire Flag Day.

The Flag Day in aid of the Combined Hospitals' Appeal held on Empire Day, May 24th last, resulted in approximately £40,000 being raised for the Fund.

Of this Guy's fully contributed its share, as the following figures show:—

	£	s.	d.
Collected by the Nursing and Administrative Staff (in 353 boxes)...	740	5	0
Collected by Students (in 388 boxes)	778	12	11
Totals in 741 boxes	£1,518	17	11
In addition the following amounts were collected in the adjoining Boroughs—			
Borough of Southwark	581	0	1
Borough of Bermondsey	363	7	7
Total collected in District	£2,463	5	7

The splendid energy and enthusiasm displayed by all the Collectors is shown by the fact that the results give an average of over £2, per Box, more than double that of an ordinary London Flag Day.

Most cordial thanks are due to the ladies who so kindly came forward in response to the appeal to undertake the arduous duties of Collectors, to the Sisters, Nurses and Administrative Staff for the charming manner in which they carried out their unusual duties, and to the Students for the whole-hearted gaiety in which they entered into the spirit of the occasion.

The success of the day was in a great measure due to the hearty co-operation of the Matron and Superintendent in every effort to support the organisation of the day.

The Laidlaw Farewell Dinner.

On Wednesday, May 24th, an informal dinner, with Dr. Fison as chairman, was held at Oddenino's Restaurant with Dr. P. P. Laidlaw as the guest of the evening. Some twenty-five members of the staff and junior staff were present, amongst whom were those most intimately associated with him in his work at the Hospital. Although the dinner was an informal one. it served to emphasise the high esteem in which Dr. Laidlaw was held by all who came in contact with him. Since his departure from the Hospital many have felt acutely the gap that has been left.

It has been suggested that as a further mark of appreciation, and a more lasting one, a fund should be established to endow a small prize to be awarded annually to the student who reads the best paper on a pathological subject before the Physical Society. Already we are pleased to announce that a sum of about £40 has been promised, and it is hoped that other members of the Hospital, past or present, will increase this to about £100. Subscriptions may be sent either to Professor M. S. Pembrey, Dr. R. D. Passey or Mr. J. J. Conybeare. Any sums, however small, will be gratefully accepted. The total number of subscribers and the total sum subscribed will be published in a later number of the GAZETTE.

Pass List.

L.D.S.

FIRST PROFESSIONAL EXAMINATION, MAY, 1922.

Part I.—Mechanical Dentistry.

Part II.—Dental Metallurgy.

Ackroyd, F. M.
*Brooks, H. G.
Crocker, E.
†Head, W. L.
Lingwood, C. D.
Parkinson, N.
*Price, T. A. L.
*Corry, E. B.
*Pleasant, S. A.
*Saint, N. H.
*Sanderson, S. S.
*Steyn, C. L.
*Tregarthen, G. G.
*Williams, H. P. R.
†Benson, W. L.
†Boulton, N. L.
*Beresford, W. P.
*Berry, T. B.
*Berwick, W. E.
*Brigham, W. E.
*Foster, W.
*Foy, W. H.
*Glennie, G. M.
*Griffith, D. W.
*Jackson, A. R.
*James, D. A.
*King, A. F.
*Perkins, A.
*Danino, A. A.
†Brittan, W. S.
†Cambrook, J. D.
†Clancy, T. O.
†Gerrard, P.
†Graham, G. E.
†Greco, E.
†Hastings, R. M.
†James, O. P.
†Myers, H.
†Pitt-Payne, W. D.

*Mechanical Dentistry only.
†Dental Metallurgy only.

Part III.—General Anatomy and Physiology.
Dental Anatomy and Physiology.

†Bingay, J. V.
Boness, W. L.
Cartwright, L. M.
Cilliers, B. J.
Crone, F.
†Davies, A. S.
†Davies, F. G.
†Doubleday, H. N.
Edwards, R.
†Fido, C. H. A.
French, S. G.
Handford, L. F.
†Howe, W. F.
†Kanaar, L. S. J.
†Lloyd, J. E.
Meskin, M. W.
†Orsmond, W.
Parker, A. F.
†Reynolds, A. W.
Roberts, V. R.
†Tran, R. A.
Urquhart, J. L. T.
Van der Pant, F. N.
Van Noorden, E. A. J.
Wakeford, C. A.
Walmesley, E. S.
*Mutch, S. R.
*Wayman, H.

*Passed in Dental Anatomy and Physiology only.
†Passed in General Anatomy and Physiology only.

M.B., B.S. London.

FINAL EXAMINATION, MAY, 1922.

Honours.

Maizels, Montague (distinguished in Medicine).
Massie, Grant (distinguished in Surgery).
Richards, E. H. (distinguished in Forensic Medicine).

Pass.

Biddle, Eric.
Douthwaite, A. H.
Levieux, H. T.
Tilak, H. T.

Change of Address.

Frank Cook, F.R.C.S., 14, St. Thomas's Street, London, S.E.1. Telephone Hop 5318.

W. Burridge, M.B., B.Ch., 177, Strada Ridolfo, Sliema, Malta.

W. H. Grace, M.B., B.S., Roodee House, Chester.

Martin Braun, B.A., L.D.S., R.C.S., Dominion House, 141 Longmarket Street, Cape Town, S. Africa.

J. Aston Martin, 24, Grange Road, Eastbourne.

H. A. Spouse, Cambridge House, 18, Cambridge Road, Hastings. ('Phone 589.)

F. N. Sidebotham, M.D., Raleigh House, Ottery, St. Mary, Devon.

Major and Mrs. F. A. Barker, I.M.S., 6, Kensington Court Place, W.8. (Or London School of Tropical Medicine Endsleigh Gardens, N.W.)

Lt.-Col. M. H. Thornely, I.M.S., 21, Alexandra Road, Epsom.

The Causes and Prevention of Dental Caries.

Paper read before the Dental Society by Mr. S. P. Meacock.

Mr. President and Gentlemen,

Dental caries has become so prevalent in recent years that it is now the most common disease to which the human race is subject. Irregularities in the arrangement of the teeth amongst civilised races are also very prevalent. This fact was impressed upon me a few months ago whilst in the Children's Department, when one morning a small girl's mouth was examined and found to be free from any signs of caries while the arches were well formed and the teeth regular. No sooner was this condition discovered than impressions were taken and models prepared for the Museum.

Since one so rarely sees a normal dentition, it will be as well to consider one for a few moments before proceeding with the causes of dental caries.

In a normal dentition the teeth of both upper and lower jaws form wide arches, and the teeth are placed regularly in the arch. The upper cheek teeth have their lingual cusps occluding in the fissures of the lower ones; whilst their buccal cusps lie external to those of the lower teeth. The upper incisors overlap the lower, so that when in use they have a cutting action.

Looking at the individual teeth it will be noticed that they only touch their neighbours at one point: known as the point of contact. In the molar and premolar region it is important to notice that the point of contact is higher than the adjacent tooth substance, that is, the surface of the tooth slopes down into a pit or fissure. In occlusion a cusp of an upper tooth presses food against the contact point, dividing it and pressing it into the pits and fissures, and not down between the lower teeth. The cusps of the lower teeth act similarly in relation to the contact points of the upper teeth. The space that exists below the contact point (above in the upper) is nearly filled by a papilla of gum, which secretes an alkaline fluid.

A normal diet consists of proteids, fats and carbohydrates, not subjected to previous preparation. Thus the fat and proteid would be eaten uncooked and carbohydrates obtained by chewing roots and berries. An uncivilised diet would therefore require much more mastication than a modern one, even the carbohydrate part would have to be chewed, whilst we simply suck sweets and lumps of sugar or swallow mashed potatoes.

During the mastication of a normal diet in a normal mouth the food is ground between the molars and premolars; the fibrous part is crushed over the contact points and spread over the occluding surfaces of the teeth. The small particles and fluids expressed from the food by the action of mastication and mixed with the saliva are collected on the back of the tongue, to be swallowed. Whilst that not sufficiently ground, mostly the fibrous part, is again subjected to the process of mastication and any small particles or fermentable fluids are thus brushed off the occluding surfaces of the teeth. Sim Wallace has described this fibrous part of the food as "Nature's Tooth Brush."

It is quite possible for small particles of food to be left on the lingual and buccal surfaces of the teeth, but these are normally removed by the action of the tongue, cheeks and lips; others may be left between the teeth and are not removed by the tongue, etc., or by the flow of saliva between the interspaces during the movements of mastication. In the normal mouth in these spaces is present a film of viscid albuminous material, which prevents particles and fluid food from getting into contact with the enamel; furthermore numerous bacteria are present; which remove all debris on the surface of this film.

Thus it would appear that, given a normal dentition consuming a normal diet, nature has provided the means for keeping the teeth clean and polished, and the mouth free from all debris likely to undergo degenerative changes in it, and that Dr. Pembrey is justified in stating "Caries is proportional to the number of dentists advocating the use of the tooth brush."

Like other diseases caries has an exciting cause as well as predisposing causes. It is generally agreed that the exciting cause is the production of acids by the action of bacteria on food particles and fluids in the mouth, during the intervals between meals, that these acids get into contact with and dissolve out the calcium of the enamel, which is so highly calcified that practically no organic matter is left. Once the enamel is removed the acids decalcify the dentine; but since this tissue is not so highly calcified as enamel it needs the presence of a different type of bacteria to remove the decalcified dentine. These bacteria are also present in the mouth and once the dentine is decalcified they get into the cavity and produce the necessary proteolytic ferments to remove the decalcified dentine.

It can often be observed that arrested decay occurs in a distal cavity when the adjacent tooth is lost. Thus showing that the source of acid for decalcification has been removed and the proteolytic ferments have nothing to act upon.

So to prevent the occurrence of caries it is essential to remove the source of acids. Before this can

be done it is necessary to find which foods are converted into acids in the mouth, and what conditions favour this acid formation.

The text books give tables showing the products of decomposition of the foodstuffs, and they seem to agree that proteids yield alkaline or neutral products and that fats may form fatty acids, but this is extremely doubtful. Carbohydrates, on the other hand, are capable of producing acids—mostly lactic acid; cellulose is probably unaffected. Sugars are converted either directly or indirectly into lactic or other acids, whilst starch may pass through a process known as mannitic fermentation, which results in the formation of mannite and gum, as well as fermentation into lactic and other acids.

It seems, therefore, that the source of acid is almost entirely from carbohydrates and that any conditions which will help these carbohydrates to lodge on or between the teeth are predisposing causes of dental caries. Thus—

Pits and crevices in the teeth;
Irregularities;
Recession of the gum; and
Mannitic fermentation of starch

are some of the predisposing causes of caries.

In uncivilised races caries is non-existent, or almost unknown; whilst in civilised races it is the most common disease; so changes brought about by civilisation seem to be responsible for its occurrence. The chief function of the teeth is the mastication of food, and this has been greatly altered by civilisation, especially that portion of the diet which it has been shown is the source of the acid, —hence caries. Fats, as a source of energy, have largely given place to carbohydrates, and so civilised races are exposed to a greater supply of acid-producing substances and are more likely to have caries.

Again, instinct has caused man to seek nourishing foods as free from the non-nourishing fibrous tissue as possible; this instinct has considerably helped him during evolution, and he is thus able to manage with a shorter intestinal tract than his predecessors. The benefit of a highly nourishing diet is seen in the sudden rise of Japan, which has been said to be due to the consumption of meat instead of the low proteid diet of the Japanese prior to the arrival of Europeans in Japan. This instinct for concentrated nourishment aided by civilised methods and machinery has resulted in the removal or destruction by cooking of the fibrous elements of the food. Thus, flour mills, rice mills, sausage mills, meat juice factories, and sugar refineries give us the nourishment without the fibrous tissue. In other words, our instinct for nourishment, helped by civilised processes, has removed "Nature's Tooth Brush," and changed our diet so much that civilised races are in far greater need of the cleansing action of "Nature's Tooth Brush" than savage races ever were. Not only are more carbohydrates consumed, but they are taken in a very fine state of division and therefore more likely to lodge in the mouth and are more easily acted upon by the acid-producing organisms in the mouth. Thus, the pits and crevices on the occlusal surfaces of the molars and premolars become filled with carbohydrates in a very fine state of division or in solution, and there is no fibrous element to clean the teeth, and so occlusal cavities are directly due to changes wrought by civilisation on the diet.

It is quite possible that the next step will be that civilisation will provide food in capsules, much in the same way as chemists prepare drugs for consumption. By that time man's instinctive desire for nourishment should be well satisfied and the retention of lower dentures will not be an all important problem in prosthetic dentistry as it is to-day.

In infancy, by producing gastro-intestinal disturbances, diet is a cause of hypoplastic teeth, and therefore a predisposing cause of caries. Lack of vitamines in manufactured milks causes derangement of the processes of metabolism and the infants are therefore unable to assimilate the foods supplied. This will stunt growth and predispose to irregularities and caries.

Infants fed naturally, by mothers receiving efficient diets themselves, are not predisposed to these complaints and moreover the action of suckling simulates very closely that of mastication and is not purely suction, the breast tissue being squeezed between the gums. Here again an infant fed by civilised means is not exercising its jaws or moulding them by pressure against the breast; and so a faulty diet is a predisposing cause of caries, as irregularities are more prevalent amongst bottle fed infants than among those fed naturally.

Endocrinologists tell us that the gonads, including the suprarenal cortex, produce lack of calcium by preventing assimilation of ionized calcium. Thus at puberty the saliva lacks alkalinity and calcium, and rapid caries occurs at this age. Similar conditions exist during fevers; in this case the saliva can be made normal by feeding mixed gland secretions.

One often hears a statement made that the civilised jaw has been reduced in size to a greater extent than the teeth; and it has been suggested that sexual selection is the cause of this reduction; but when one considers the results of overcrowding that would be the result of a small jaw and large teeth, it is difficult to believe that men have selected women suffering from caries, toothache, suppurative roots, anæmia, digestive troubles, ill-health and ill-temper—all results of overcrowding. Moreover, if this were so it would be an example of the preservation of characteristics detrimental to the race; which is hardly likely to occur. People with large roomy mouths often appear to have small oral orifices.

It is highly probable that sexual selection of small teeth is beneficial in civilised races, and that this factor has resulted in the third molars being diminished to a greater extent than any other teeth. Thus people with small third molars stand a better chance of escaping septic conditions resulting from their partial eruption or the pain of impacted wisdoms.

When teeth erupt the crown is fully formed, irrespective of the amount of use the jaw has had, or of the size of the jaw. This apparent excessive reduction of the jaw can be traced to changes in a single generation, and is due to imperfect development of the jaws caused by the reduction of the proper stimuli of mastication and natural feeding in infancy. So civilised diet is responsible for the excessive reduction of the size of the jaws in relation to the size of the teeth.

Sim Wallace made numerous observations which show that proper use of the jaws and the muscles of mastication, including the tongue, is largely responsible for the development of the jaws and the production of regular arches of teeth. He states that people with large tongues have large roomy dental arches and regular teeth. Cretins, who have, pathologically, large tongues, also have good arches. Thus it is quite possible that a civilised diet by removing the fibrous tissue obviates the necessity of chewing. Sim Wallace estimates that a natural diet requires ten times more mastication than a civilised one, so the tongue of a civilised person does not get properly developed and the pressure of a developing tongue on the teeth is more or less absent in civilised peoples, and the teeth are not moulded into two large arches and mal-occlusion is more likely to occur.

Much stress has been laid upon the production of irregularities; so it becomes necessary to consider in what ways these variations from a normal dentition may be predisposing causes in the production of caries. In the first place, the arrangement of the contact points will be interfered with in some part of the mouth, and food becomes very liable to be wedged between the teeth and assist acid-forming foods to remain in contact with the teeth. In the incisor region very large portions of, or even complete surfaces of adjacent teeth are often found to be in contact, resulting in a condition ideal for holding soluble acid-forming foods in touch with these large areas of tooth enamel by capillarity, much in the same way as cavities are produced round the contact points in a normal dentition fed on a civilised diet.

The papilla of gum with its beneficial alkaline secretion is, in these cases, either pressed down and removed by inflammatory processes or is almost non-existent where two teeth lie with the whole approximated surfaces in contact. So, in irregularities with the receded gum or very small papillæ, less alkaline secretion is formed and the conditions for retention of food are increased and more alkaline secretion is needed.

Much research work has been carried out to find whether the composition of the teeth of civilised races is degenerate and therefore unable to resist the carious process. Many have held the structure of the tooth responsible for the vast increase in the prevalence of caries, but as already pointed out all that is necessary is the production of acid to decalcify the tooth substance, and therefore it would seem that the structure of the tooth can only affect the rate of progress of the disease once the acid formed gets into contact with the enamel.

Clinically the teeth of those suffering from gout are known to be very hard and well calcified, whilst those of consumptive patients are very often appreciably softer and the caries of the rapid type. Statistics seem to prove that districts supplied with a high proportion of calcium salts in the water are freer from caries than those with a low proportion. This is probably because the acids present are able to attack the better calcified teeth less readily than those of inferior structure, and so the carious process is often averted; yet caries is far less prevalent in the lower incisors than in molars, although they are not so highly calcified as are the molars.

Practically the whole of a modern dentist's time is spent in the treatment of caries. Most students spend two years in the conservation room restoring tooth substance lost by the ravages of caries, possibly with very little thought about what is causing this destruction of teeth, which, in spite of all efforts of the profession, seems to be far more prevalent than ever.

In medicine and surgery, treatment is directed first of all to remove the cause of the trouble, whilst in dentistry the results of the trouble are treated and the cause left unthought of in the majority of cases.

Proceeding, therefore, on similar lines of treatment as are adopted by the medical and surgical professions, steps must be taken to remove the predisposing causes in the future generations by proper feeding in infancy and modifying the diet so that the fibrous element is replaced as far as possible.

The introduction of chewing gum is possibly a step in this direction, since the continuous simulation of the movements of mastication will help to stimulate the growth of the jaws, and the flow of saliva caused by the movements of the tongue and cheeks will wash away much of the debris left between the teeth after meals.

It is theoretically possible that, if these conditions could be brought to perfection, a generation would be produced possessing perfectly constructed teeth set in normal arches. Then, having produced

all the conditions provided by Nature in a normal dentition, for the self-cleansing of the teeth and mouth, it would be possible by feeding on a natural diet to prevent the occurrence of caries in all future generations.

Turning from the ideals to be aimed at to the state of affairs in the present generation we find that the predisposing causes already exist in the form of:—

Irregularities;
Receded gum;
In some cases defectively constructed teeth;
Defective diet already described; and
Harmful results from the misuse of artificial cleansing apparatus.

It is a practical impossibility to remove all these causes at once and so treatment should be directed to assist Nature to carry out her efforts to prevent the lodgment of food which causes caries.

Surgeons do not remove the tubercle bacillus to cure tuberculosis as this is a practical impossibility, so they immobilise the infected part as far as is possible and thus help Nature to surround the bacilli with fibrous tissue. The patients are also removed to a different environment to avoid reinfection and the recurrence of the disease.

Thus, in the present generation every effort should be made to assist the natural processes for cleansing the mouth and teeth in such a manner that patients are likely to co-operate.

First the contact points must be carefully restored and cutting for the prevention of caries given due consideration.

Patients must be instructed how to remove particles of food with the tooth brush without damaging the teeth, gums and protective albuminous film present between and around the necks of the teeth. The starchy film often produced by such articles of diet as cakes and biscuits is an entirely different thing and should be brushed and washed off.

The beneficial action of massage on the gums carried out normally by a fibrous diet should be replaced by brushing them with a saline solution. This will stimulate the mucous membrane and the production of the alkaline secretion of the papillæ.

The mouth should be well rinsed with the saline and efforts made to swill particles loosened by the tooth brush and soluble food from the teeth and the interspaces not accessible to the tooth brush.

The brush should be rinsed in the remains of the saline and put away to dry. In this way the concentrated saline acts as a disinfectant and a serious objection to the use of the tooth brush is removed.

Treatment on these lines can be carried out and patients usually co-operate, as the ease with which these last few processes can be performed with a tooth brush, a glass of water, and some common salt appeals to them far more than the use of disinfectant tooth powders and pastes, which instead of helping nature inhibit the action of bacteria in cleaning up debris and may also remove the albuminous film which keeps the acid away from the enamel.

People addicted to bad habits are often fully aware of the dangers they run, but still they carry on and often bring about their own ruin. Civilised people are very much like these individuals and although many educated people are aware of the ill-effect of errors in diet they make no real effort to avoid caries.

It is impossible to revert to a natural diet, but much improvement could be made in this direction if people were taught the value of finishing meals with some form of food containing fibrous tissue, especially the last meal before retiring for the night. A move in this direction is the prevalent custom to finish a meal with dessert. The vast masses of civilised people are as yet ignorant of the beneficial effect of a carefully chosen diet, and one of the things the Ministry of Health has yet to do is to see that public dentists educate school children in some of these matters, whilst every dentist can instruct his own patients.

Mr. Parfitt quotes a case in which the patient fed largely upon a milk diet ordered by her doctor. Several cavities were present and there was also evidence of decalcification in other places. The cavities were filled and the patient instructed to clean the teeth every time after taking the milk. Some years after the decalcified areas had not become carious, thus proving that artificial cleansing is a preventative of caries and that many cases of caries could be avoided by attention to diet.

It would therefore seem that the most potent cause of caries is the production of acids in the mouth, resulting both directly and indirectly from a civilised diet and that treatment should be directed towards assisting natural processes of obtaining oral hygiene by modification of the diet and artificial cleaning of the mouth.

The Pavy Gymnasium.

At the Annual General Meeting, held on June 1st, the following officers were elected:—

President—A. W. Ormond, Esq.
Hon. Treasurer—W. M. Mollison, Esq.
Hon. Secretary—G. V. Lloyd-Williams.

Committee—Messrs. H. Chapple, M.Ch., F.R.C.S., S. P. Meacock, J. D. S. Thomas, W. H. Foy, N. M. Holloway, C. H. Johnson, N. L. Lloyd.

Guy's Hospital Past and Present Nurses' League.

The Twenty-Second Annual Meeting and the Fourteenth Annual Dinner of the Guy's Hospital Past and Present Nurses' League was held on Friday, May 5th, 1922. So many applications had been made for tickets this year, that all the available seats were taken two days before, and Members who applied after the closing date were unable to obtain seats. The guests began to arrive in the Nurses' Home soon after 6 o'clock, and there were many happy greetings between friends and fellow workers who had not met for years. At 7 o'clock, the large Nurses' Dining Hall was quickly filled, and we are sure it must have been a source of great satisfaction to Dame Sarah Swift (whom we are always so glad to have with us on these occasions), to see how much the League Dinner, which she inaugurated in 1909, was appreciated and enjoyed each year by all Members of the Past Section of the Nurses' League. The Dining Hall looked very charming, the tables being prettily decorated with daffodils, sent by the Treasurer, the Viscount Goschen; the Home Sister and her Assistants were to be congratulated, all arrangements being carried out so successfully, and everyone agreed that the Dinner was the best that had been given.

Directly after Dinner, a move was made to the Nurses' Recreation Room for the Annual Meeting, and the Matron in welcoming so many Members that evening, expressed the great pleasure it was to have Miss Haughton with them, and said that she hoped that now she was getting well and strong again, she would soon be able to take an active part in their Annual Meetings. It was also a great pleasure to welcome Miss Oxford and Miss Strick; she was sorry that Miss Sheldon, who had recently retired from the Nurses' Institution, was unable to be present. Many Nurses owed Miss Sheldon a great deal for her kindly help, sympathy and teaching, without which they would never have reached the goal of a three years' Certificate, and she was sure that the best wishes of the Meeting would go to her for much happiness in her future work.

The Matron then said she wished to bring to their notice the Garden Fête, to be held in the grounds of the Hospital on June 29th, organised by the Ladies' Association in aid of the Hospital Funds. This would take the place of the Annual Garden Party, no invitation would be sent out, but League Members could obtain tickets of admission, price 1s. for their friends and themselves, by applying to the Matron's Office early in June. There were to be Stalls for the sale of various articles, cakes, sweets and also a second-hand Stall for books, china, glass, etc. She would be pleased to receive gifts for any of the stalls, especially the second-hand stall.

The business of the Meeting was next proceeded with, Miss L. E. Jolley, on the invitation of the Matron, took the chair, and signed the Minutes of the last Meeting, which were as usual taken as read, in order to save time.

She then called upon the Matron, as Hon. Secretary of the League, to give the report of the year's work, and in the absence of Mrs. Hughes, the Hon. Treasurer, to make the financial statement.

Between 80 and 90 Present Members have been transferred to the Past Section during the year.

About 300 Week-ends and Days off have been spent at the Cottage during the year, and nearly 900 short visits have been paid for tea and breakfast. The decrease in the number of visits at the Cottage is accounted for by the Nurses being unable to play tennis owing to the excessively dry season.

Nearly 1,000 volumes have been taken out of the Nurses' Library during the year.

The Tennis Section again took part in the Tennis Tournament arranged by the *Nursing Times*, for which there were 31 entries, including the large General Hospitals, Infirmaries, and Fever Hospitals. After several well contested games, we were successful in competing in the Final, but we were unable to win the Cup from the holders, "The London Hospital Team," who were much stronger in their play.

The Fagge Tennis Challenge Cup was also well contested, and although the entries were smaller than last year, the cup-ties took a long time to play off, owing to our being handicapped in the first place by the Hard Court being under repair, and afterwards by our not being able to play upon the court, when finished, as the use of water was forbidden by the authorities on account of the drought. The Secretary of the Student's Tennis Club, however, kindly came to the rescue, and obtained permission for us to use their courts at Honor Oak Park, and we were thus able to have the final at the end of August. This year, Nurse Vian was the winner. She beat Nurse Stubbs, the runner-up in two straight sets. Mrs. Mollison very kindly gave two prizes again this year, and she took much trouble in coaching the team all the season. This was greatly appreciated.

The dry summer of last year was so detrimental to the grass tennis court, that it was found to be necessary to make a new court altogether. We obtained estimates for putting down a grass court and also a hard court, and after much thought and discussion, the Council decided to have a second hard court put down. The En Tout Cas Co.

have the work in hand, and we hope before many weeks are over, that the new court will be available, and this will give other Members who are not playing in the Tournament, an opportunity of having a game of tennis.

The Nurses' Swimming Club has worked very hard during the year. In July, a Hospital Team of six of the best swimmers, took part in the Inter-Hospital Swimming Sports held at the Bath Club, and the Guy's Team was successful in winning this year a very handsome Silver Challenge Cup presented by Sir Alfred and Lady Fripp, to be competed for each year by the Nurses in the various Hospitals. Our own Annual Swimming Gala in the Nurses' Home took place on October 12th. Lady Fripp has very kindly given us a Silver Challenge Cup to be competed for each year, and the Nurse who gains 65 per cent. marks for diving and style, is to have her name engraved upon the cup. This year the Cup is held by Nurse Garland.

The Musical Society has also met for practices during the year, but so far, has not been able to give a Concert.

The Dramatic Society has also been very energetic. One evening, the Rev. Stewart Headlam came and gave us a very interesting Lecture on the Acted Shakespearean Play, and the work of the London Shakespeare League, and in February, the Members of the Society, both Sisters and Nurses, gave us two very enjoyable dramatic entertainments, a collection being made to swell the funds for the new tennis court, and we are looking forward to another entertainment being given this year.

The Photographic Society gave a Lantern Lecture in February, and also made a collection for the new tennis court.

I am sorry to say that so far the Debating Society has not been able to arrange any evenings for debates.

With regard to the Exhibitions now on view in the Sitting Rooms:—The number of entries in the Needlework Exhibition is much smaller than last year, the Nurses and Sisters working in the Hospital not sending in nearly so much work. Mrs. Burgwin, who again kindly acted as Judge, said, however, that the standard of the work shown was very high, and she had great difficulty in awarding the prizes.

The number of entries for the Photographic Exhibition is much larger, there being over 100 entries for Class C. (not the entire work of the Exhibitor). This year, Mr. Hollyer has again kindly acted as Judge, and has given us much useful advice and criticism.

Since our last Meeting, I much regret to record the death of one of our Past Members, Miss Sarah Ellis, who died at Wanstead in January last, after a short illness of Pneumonia following Influenza. Miss Ellis entered Guy's Hospital in 1889, and joined the Private Nurses' Staff in 1894, retiring in March, 1912.

In the absence of Mrs. Hughes, the Hon. Treasurer, I have much pleasure in presenting the financial statement for the year.

The Hon. Members' subscriptions are not quite so much as last year, some of the subscriptions having been received too late to be included in the year's accounts. The Present Members' subscriptions show an increase, owing to there being a greater number of Nurses working in the Hospital. The Past Members' subscriptions also show an increase, more Members having paid the composition fee of 1 guinea for 10 years. The subscriptions and grants have again covered the working expenses of the Cottage and the different Clubs, and also paid a sum of £37 10s., as part cost of the Railway Tickets for Members to visit the Cottage at Honor Oak Park. The cost of putting the hard tennis court into good playing condition was a very heavy item in the year's expenditure, a sum of £84 being required.

Our income for the year amounted to £560 15s. 9d., and our expenditure, £513 19s. 8d., and with the amount carried forward from last year, we have a balance in hand of £122 10s. 5d. This balance will be required to help defray the cost of putting down a second hard court. I am glad to say that we are to-day in a sound financial condition, but we must work as economically as possible during the coming year, for the new court will cost about £250.

The adoption of the Report, including the Financial Statement, was moved by Dame Sarah Swift, seconded by Miss Haughton, and carried unanimously.

The result of the ballot for Members of the Council for the ensuing year was then announced by Miss Smith as follows:—

Choral Section.—Sister Evelyn (Miss Johnson), Staff Nurse Cornwall.

Swimming Section.—Sister Mildred (Miss Hughes) (re-elected), Nurse Garland.

Tennis Section.—Sister Grace (Miss Mannell) (re-elected), Staff Nurse Stubbs (re-elected).

Garden Section.—Sister Ann (Miss Robins), Nurse Parker (re-elected).

Needlework Section.—Sister Luke (Miss Wilson) (re-elected), Nurse Buchanan.

Photographic Section.—Sister Bailey, Nurse Bishop (re-elected).

Library Section.—Sister Griffiths (re-elected), Nurse N. Webb (re-elected).

Debating Section.—Sister Naaman (Miss Dearman) (re-elected), Nurse Watkins (re-elected).

Dramatic Section.—Sister Theatres (Miss Evershed), Nurse Lyons.

The election of Lady Fripp, Lady Hale-White, and Mrs. Robarts, as Hon. Members of Council was then confirmed, after which Miss Jolley gave a short account of prison nursing conditions.

She said the work was full of human interest, but necessarily differed very much from that in a General Hospital. In the latter, if a patient became objectionable or refused treatment, he is requested to leave, but in prison he could not be discharged, he must be put up with, cajoled, reasoned into submission, and this constituted one of the great difficulties of the work. So much patience was required in dealing with the prison type of patient, and a great deal of tact, sympathy and firmness. At Holloway, where the prisoners were all women, Miss Jolley said she did not find them on the whole, much worse or much better than other people; vice was not always the cause of their being there, sometimes the reason was sheer bad luck, often evil companions, in many instances it was a weak will or an uncontrollable temper that had resulted in the commission of the crime.

Some people thought Nurses were wasted in prisons, but this was not the case, and she spoke of the great assistance she had received from Miss Stedman (a Guy's Nurse) who had been in charge of one of the Observation Wards, and now she had also the help of Miss R. Pecker, another Guy's Nurse, who had been appointed Sister-in-Charge of one of the Hospitals. She hoped in time, prisons would be reduced in size and only contain able-bodied criminals. It was the feeble minded, the epileptics and the mentally deficient, so often found in prisons that made the work of nursing so difficult. In her opinion, such people should not be there at all, but should be put into special homes where they could be properly looked after, and she asked those present to use any influence they might have to get these Borderland Homes established. There would be a great scope for Nurses in taking charge of these Homes, and the patients would improve more rapidly than in the whitewashed walls of a prison cell, which were not inspiring. All prisoners were now humanely treated, the object of their detention being to make useful citizens of them, but while it was not desirable to make prisons too comfortable, it was necessary that those who came under medical degrees of unfitness, should be separated from those who were in normal health. She gave two instances which actually occurred. A woman discharged from Holloway at midday, was knocking at the gate asking to be taken in, "if it was only for the night." Another discharged prisoner set out to go to Liverpool, but by the time she got to Hitchin, she broke the window of a chemist's shop, so that she might be brought back to Holloway.

Working in a prison for the first time, Nurses would find the necessity for care in trifles much greater than in a General Hospital. Nothing whatever must be left about, a piece of string dropped on the floor of a Hospital Ward would just be picked up, but in prison, it must be immediately put away, lest someone should tie it round her neck. Keys put down on a table for a minute, have a trick of disappearing, and giving rise to all sorts of trouble. Prisoners also have many rights and privileges which must never be ignored. If one objects to her dinner, and considers it insufficient, she has the right to be taken to the kitchen and see it weighed. Much trouble is sometimes given by epileptic patients, who will on the slightest provocation "boil over," smash windows and behave like wild animals, and this called for great resource, calmness and presence of mind in the Nurse. Improvements were slow in the Prison Service, but things were coming right by degrees. The Commissioners are now backing up the Nurses, and once a good nursing service is firmly established, the work would be much easier, and any nurse who wished to do pioneer work, would find a most useful sphere of work open to her in caring for these poor people.

Miss Jolley then presented the Prizes awarded to the successful Exhibitors in the Needlework and Photographic Exhibitions, which were placed at the disposal of the judges by Lady Bective, Lady Lane, Lady Perry, Mrs. Cosmo Bonsor, Mrs. Cameron, Mrs. Eason, Mrs. Fagge, Mrs. Hughes, the Hon. Mrs. Molyneux, Mrs. Rowlands and Mrs. Steward.

NEEDLEWORK—LIST OF AWARDS.

SECTION I. (Exhibits that have not been washed or cleaned).

Class A.

Plain Needlework—

1st Prize.—Nurse M. Humphreys.
2nd Prize.—Sister Luke (Miss O. Wilson).
Highly Commended.—Sister Dixon and Nurse V. Murray.

Darning—

1st Prize.—(Sister Luke (Miss O. Wilson) and Nurse Page.)

Patching—

Prize.—Nurse K. Adams.
Highly Commended.—Nurse Henry.

Class B.

Fancywork—

1st Prize.—Miss Beryl Binning.
2nd Prize.—Sister Theatres (Miss Evershed).
Highly Commended.—Miss W Venning and Miss E. Wilkins.

Class C.

Lace and Crotchet—

1st Prize.—Mrs. Wood (neé Douglas).

2nd Prize.—Miss M. Collier.

Highly Commended.—Sister Grace (Miss Mannell) and Nurse Lyons.

Knitting—

1st Prize.—Nurse York.

2nd Prize.—Miss F. Tubbs.

Highly Commended.—Miss J. Worthington and Miss K. Murphy.

Class D.

Dressmaking and Millinery—

Highly Commended.—Nurse Sheppard.

SECTION II. (Exhibits that have been washed or cleaned).

Class A.

Patching—

Highly Commended.—Nurse Betts.

Class B.

Fancywork —

1st Prize.—Miss C. Pearce.

2nd Prize.—Nurse H. Lucas.

Highly Commended.—Miss S. Pollard.

Class C.

Lace, Crotchet and Knitting—

1st Prize.—Miss K. Jackson.

2nd Prize.—Sister Light (Miss Looker).

Highly Commended.—Sister Dixon.

Class E.

Miscellaneous—

Very Highly Commended.—Miss Beryl Binning.

Highly Commended.—Miss F. Tubbs, Miss M. S. Robertson and Nurse Lamb.

Special Prize.—Specimens of Plain and Fancy Needlework.—Miss E. Latham.

PHOTOGRAPHS—LIST OF AWARDS.

Class A.

(Entire work of Exhibitor.)

1st Prize.—Tree Studies. Miss L. Oldendorff.

2nd Prize.—Rippled Sands. Miss H. Edmonds.

Special Prize.—A Quiet Byway. Miss M. Smith.

Class B.

(Entire work of Exhibitor who has not won an award.)

Prize.—Rocks at Nevin Pwlheli. Miss W. Johnson.

Class C.

(Not the entire work of Exhibitor.)

1st Prize.—Rough Sea on the Northumberland Coast. Miss S. Hadcock.

2nd Prize.—A Convent Garden. Miss B. Binning.

3rd Prize.—The Hills of Shanhaikwan. Mrs. Tatham.

The Meeting concluded with hearty votes of thanks to the retiring Members of Council, Mrs. Walter Burns, Mrs. Mollison and Mrs. Steward; to Mrs. Hughes, the Hon. Treasurer; to Miss Hogg, the Hon. Secretary; to Miss Smith; and to Miss Jolley, for presiding.

Tea and Coffee were then served, after which Members inspected the Needlework and Photographs on view in the Sitting rooms, and were shown over the new Preliminary Training School by the Pupils Sisters.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

When the "Gazette" was Young.

DEAR SIR,—Before leaving home for a holiday I wish to send you a line to express my appreciation and grateful thanks for the articles you have published from a Special Contributor "When the GAZETTE was Young." I do not know whether to marvel most at his extraordinary memory for details occurring so long ago, or at his delightful consideration for the feelings of any who may still be interested in the personality of the members of the staff and students referred to at Guy's 50 years ago.

The articles are, I am sure, very interesting to present day Guy's men, but such interest cannot compare with that which must be felt by those of his fellow students who still live to enjoy reading them.

With the writer's help I think I manage to recall almost every man and every matter that he mentions, though without his help many would have remained a closed book to me.

Amongst the cases I recollect very well the man who cut his throat by falling out of bed on to a bed chamber, and wounded it so deeply that he cut off a transverse process. An interesting point not mentioned was that the wound opened the jugular vein and on handling it, as House Surgeon, I had my first and best experience of the effect of air entering a large vein. I remember holding the vein whilst my fellow House Surgeon, H. Hetley, sutured the opening. The patient made a good recovery.

I have always very thoroughly appreciated and been most thankful for the practical character of the training at Guy's. It was in marked contrast to the Edinburgh training of those days, where they had so many students that a couple of dressers would be detailed to take one ulcer of the leg. Forty years ago most of one's fellow House Sur-

geons in Liverpool came from Edinburgh, and as a rule they had not passed a catheter.

How well I recall the various members of the Staff mentioned by your correspondent, and how much I appreciate the gentle and affectionate way in which he writes of their foibles and teaching. No less delightful is it to be reminded of men like Jim Hainsby, the anatomical porter, with his shiny top hat. But the writer is too gentle to write, or you, Mr. Editor, to print a good few of the recollections possibly still extant of this celebrated practical anatomist.

Another man referred to—Ted Hunt the bath man—I remember very well, and especially as a "case." Poor chap he ended his days in a bath at the time I was House Physician. At this period, 1874—75, there was a regular epidemic of hyperpyrexia in rheumatic fever cases, and I was in the thick of it. One fellow-student I bathed 27 times in 17 days, and each time for a temperature of 107°. He recovered and I used to see him for years after. Ted Hunt, unfortunately, was not in the wards, but in a small house in the grounds, and I did not see him till his temperature was over 110°. We got the bath at once, but it rose to 111·4° before we began to subdue it, and he never recovered consciousness.

It was a strange epidemic, for I found it going on at the Royal Infirmary in Liverpool when I arrrived from Guy's in 1875, and had the same success with the bath. I never hear of such a condition now.

These reminiscences are, I am afraid, of interest only to a small group now, but at any rate the writer of the articles in the Guy's Hospital GAZETTE has given great pleasure to at least one old Guy's man.—Yours etc.,

FRANK T. PAUL.

31, Rodney Street,
Liverpool.

SIR,—Some time back I treated a wasp sting by taking the poison away with a hypodermic syringe and injecting a minute quantity of very dilute ammonia.

The syringe was a dental syringe with a small needle. The point of the syringe was inserted as near as possible to the sting, after the skin round was painted with iodine. No swelling resulted and no pain. It has struck me that a hornet sting might be treated in the same way, also a snake bite. The patient, my wife, was stung a quarter of an hour before.—Yours faithfully,

S. J. F. WEBB.

6, High Street,
Bishop's Stortford,
Herts.
31st May, 1922.

A Memory of Dr. Philip Pye-Smith.

SIR,—Mr. Wells once told me (I know not on what authority) that Carlyle deemed Dr. Pye-Smith the best educated young man in London; and a Surgeon, after the elapse of thirty years, recently spoke feelingly to me of his coming up to Guy's—a stranger—and of Pye-Smith's kindness to him.

By chance one afternoon in the days of his retirement, I met him at Paddington and was destined to accompany him part of his journey. We soon fell to talking of men, women, and books. My reference to that tribute to Fagge in the Preface of Fagge's "Medicine, "his quiet smile of doubt or his eager nod of assent," pleased him. He asked who was my favourite poet, and I answered Matthew Arnold. He seemed unfavourably surprised but after a pause repeated from "Requiescat":

"Strew on her roses, roses,
And never a spray of Yew!"

And then added: "As you become older, you will not sleep so well and his lines will run in your memory, and give you pleasure and comfort."

Dr. Pye-Smith was well read in the Eighteenth Century men—and I little. He quoted some beautiful verse from Pope, and then with that curious humility when he approached literature, sought my opinion.

Once at a meeting, he said, Lord Rosebery was present and he entreated him to speak, but the man of many moods was silent, and Dr. Pye-Smith addressed it.

As we drew near Beaconsfield, he spoke of Burke being buried in the church. I gave Burke's outburst on the death of Marie Antoinette, the tears wetting the paper on which he wrote, and Morley's reply, "Did not the agonies of a nation deserve the tribute of a tear?" "No," said Pye-Smith, dogmatically, "they brought it on themselves." I mentioned Waller, the poet, was buried at Beaconsfield as well. "Waller was a turncoat." I reminded him Falkland changed sides. "Ah, yes," was the reply, "but for honourable reasons." He could not understand how John Morley came to write some of his books, but asserted he had no doubt Morley had now altered his views. He told me that at a gathering, one evening, when all the other guests had gone the weather was wet and stormy, and he and Morley remained together for a time; and then added wistfully, "but Morley is a scholar and a gentleman."

As I bade him good-bye he asked me to write to him—an unfulfilled intention. For him, too, the shadows were falling. I fain would hope in those last enfeebled days, it was permitted to him for lines to run in his memory.

But it is still an inspiration to recall Dr. Pye-Smith in his prime, with his tall, erect, fresh

presence, walking down to Guy's Hospital to Hunt's House. "No hungry generations tread him down."

RICHARD GILLBARD.

St. Margarets,
Dean Road,
Willesden Green, N.W.
5th June, 1922.

Theories of Anaphylaxis.

A.—CHARLES RICHET, working from the starting point that an incubation period is necessary before manifestation of phenomena, states that the shock can only be due to accumulation of toxin in the organism.

He believes that a new substance is formed in the body—not toxic in itself—but capable of becoming toxic in the presence of a fresh dose of the injected protein.

This new substance is present in the blood, for, the injection into a fresh animal of the serum of an anaphylactised animal sensitises the latter as though it had received previously an injection of the sensitising protein. A second injection of this last serum gives rise to anaphylactic accidents. He called this substance toxogenitor.

Upon the second injection of the sensitising product, this unites with the toxogenitor forming a new substance of a different composition named apotoxine—a poison to nerve tissue—and giving rise to a special train of symptoms—"anaphylactic shock."

Extracts of the bulb of a guinea pig, killed by anaphylactic shock, when injected into the brain of fresh guinea pigs produce in the latter symptoms comparable to anaphylactic shock.

B.—According to VON PIRQUET and SCHICK the injection of the sensitising protein (horse serum in their experiments) plays the rôle of antigen and stimulates the formation of antibody.

On a second injection of horse serum given 12 days after the first, there results an abrupt union between antigen and antibody, producing anaphylactic shock.

C.—According to BESREDKA the first injection of antigen produces in the organism an antibody, taking 10—12 days to mature. He calls this antibody "sensibilism." It corresponds to the toxogenitor of Richet.

The sensibilism unites as soon as it appears with the nerve cell. It is in the nerve tissue itself that the union of antigen and sensibilism set up anaphylactic shock.

The severity of intracerebral injections can be explained by this theory. Also it explains the fact that anæsthesia by ether and chloroform prevent the occurrence of anaphylaxis by destroying the affinity of the nerve cells for poisons. But this is not all.

To explain why feeble doses of antigen are more liable to produce anaphylactic shock than big doses, Besredka contends that the sensibilism in this last case is neutralised by antisensibilism.

[According to him every horse serum contains two substances—the first named sensibilisinogen (thermostable) and giving rise to sensibilism, and the second antisensibilism (changed by heat).]

It is the abrupt union of sensibilism and antisensibilism in nerve tissues which gives rise to the sudden shock encountered after intracerebral injections.

D.—NICOLLE states that the injection of an antigen in an animal gives rise to the production of two types of antibody.

1. Coagulants.
2. Lysins.

According to the predominance of the first or second type, we get on the one hand phenomena of immunity, and on the other hand phenomena of hypersensibility.

In the anaphylactic process, the lysins act directly without the preliminary aid of coagulins, and bring about the forcible destruction of cells, toxins or albumens playing the rôle of sensitisers.

Anaphylactic phenomena would thus be analogous to those induced by poisons of Vaughan (poisons found in albuminoids and cell bodies, and extracted by alcoholic solution of sodium).

Nicolle is of opinion that anti-anaphylaxis results from reduced lytic power of serum.

E.—VAUGHAN and WICHLER, from their experiments on egg albumen, think that the first injection of egg white stimulates in the animal the production of an enzyme (zymogen).

At the time of the second injection, the enzyme by halving or splitting the particle of albumen would liberate a toxic product having a specific affinity for the nervous system.

F.—BIEDL and KRAUS were struck by the similarity of anaphylactic shock and shock following the injection of peptone to the dog (sudden drop of arterial pressure and incoagulability of the blood).

They think that the serum of a sensitised animal is able to change the sensitive substance into a fresh product of peptone class.

This substance would give rise to peripheral vasodilatation and fall of arterial tension.

In this theory the central nervous system plays no part.

Paris. O. G. HUME, M.B.
October, 1921.

When the "Gazette" was Young.

(*Concluded*).

Reverting to Pilocereus Senilis, he was naturally a witty man. Even in the post-mortem room he loved to produce logical parallels to a point where they appeared at right angles. This is the basis of the modern pun. He lived at Hornsey and often had some of the students to spend the day with him there. On one of these days at church the preacher was dwelling on the miraculous draft of fishes, and quoted the Commentator Scott on the incident. Quick as lightning Moxon turned to his companion and said, "He has no right to give us common 'taturs with miraculous fishes."

Most of the students know that the pill in the Guy's Pharmacopœia, composed of digitalis, squill, etc., which was officially known as the Pilula Diuretica cum Scillæ, was first prescribed by Dr. Addison, who always spoke of it shortly as "*my* pill," with accent on the "my." Indeed, one student of his day used to call him "my pill Addison" in alluding to him.

There is another pill, largely used in the surgery, and known as Pilula Colocynthidis cum Calomelane. This was written by Sir Astley Cooper. In his "Life" he alluded to this pill and called it "my restorative pill," and he went on to say that if ever he felt overworked and tired, with lassitude and loss of appetite, and he took one of these pills, it immediately restored him to a "bright" state. There can be no doubt that Sir Astley was speaking only the truth in saying this, but my experience has been that it is a pill that requires administering with great caution in a majority of cases.

When ex-dresser once I asked the draymen who brought the beer if they would like a tankard. A tankard was a quart flagon, and I saw a man once drain the full measure without removing it from his lips. The drayman said, "I would sooner have a couple of pills." The pills he referred to were Astley Cooper pills, and he had evidently had them before. On the other hand, I remember there were two brothers in my day at the hospital; they were both good athletes. One was Captain of the Rowing Club and the other of the Football Club. One day in speaking of this pill the footballer said to me, "There are two things I can't do (he was smoking at the time). I can't smoke shag tobacco, and I can't take Pil. Col. c. Cal. Both always make me ill."

In some of the earlier numbers of the GAZETTE topical sketches now and then, both prose and verse, were written by Albert Castor. It was to him the GAZETTE was indebted for most of its poetry; not all, for Stephenson, a re-incarnation of Shakespeare, occasionally sent in copy. In one of these there were personal allusions to the Staff which required Editorial massage. One line was entirely omitted. Stephenson was so indignant at this that he came and stormed at the Editor, and said had he known this would have been done, he never would have published it in the GAZETTE. We were much amused. Dr. Dehu, the subject of the line, always wore dark clothes, but sailor's-knot ties of most brilliant hues. The line omitted was "For this did Dr. Dehu wear his very gaudiest coloured tie." I forget the title. One short poem on "Aneurysm of the Arch of the Aorta" was written by another. Men would sit and talk by the hour, but I could not get them to put their notes on paper. They were under the impression that they were invited to write, or ought to write something monumental.

THE CORRIDORS OF TIME.

In following the progress of science and research let us not forget the past nor discard as "out-of-date" the methods and ways of former days. During the war I was amused at the frequent discovery of all old septic conditions. They were described at length, and re-named with new titles. I was amused by one writer recommending a course of Ambrose Pare and Surgery in the time of the Napoleonic wars, as it would throw a flood of light on much that was dark to him.

In the early days of the GAZETTE, the name of Sir James Paget was one which was not only of great weight at Bart.'s, but in all other hospitals in London. His work on Surgical Pathology was read by all who were working for the higher examinations. No reader can help being struck by the veneration Sir James shows in its pages for the writings of Hunter. They are quoted con-

stantly as the dicta of a man of great light. To me it was a lesson I have never forgotten. The writings and sayings of the great men of the past ought never to be thrown lightly aside. What weight even now, when all that we call "science" was dark, the thoughts of the old wise men still have. None but a very light headed person speaks disparagingly of what was once the work of the fathers of medicine and surgery. We must remember that we build to-day on the solid blocks of learning that were established by those who have gone before us. We may build upon it and add to it, but surely it is an impious thing to utterly neglect and forget it.

Many years ago a clergyman, in taking me over a battlefield in his parish, informed me that it was said that the leader of the victorious army was buried in his churchyard, sitting upright upon his horse. "Do you believe it?" I asked. His reply was earnest and solemn, "There is always something in tradition." I have never forgotten that lesson, for, some years afterwards, the bones of a horse and man were found in the churchyard in justification of the belief. It is wise never entirely to put on one side or sneer at what has once been seriously received by learned men. Even the alchemists of old groped after a truth which they knew existed.

The walls of Guy's are hoary with traditions, there is not a stone in its construction which is not associated with the great men of old. In the days when the GAZETTE first saw the light, these traditions were most loyally cherished from the greatest down to the very least, for did we not see in the hole, which, by tradition, must always be *burnt*, not cut, in a square of scorched rag used for wrapping the stump of the umbilical cord in, the crude beginnings of asepsis? It was done in the dark, but the tradition felt the light.

Where a custom, harmless in itself, has had the power of retaining its hold on the minds of able men of old, there must be truth concealed in it somewhere, waiting for the future to demonstrate. For this reason not only during the infancy of the GAZETTE, but for many previous "generations" of students, it was a point of honour to preserve, and pass on unbroken to our successors, the traditions and observances connected with our grand old Alma Mater.

A Case of Foreign Bodies in the Trachea and Intestines.

Charles R., æt. 28, was admitted in a state of collapse, into Naaman Ward under the care of Mr. Rowlands, at 6 p.m. on 9th April, 1922.

The patient was brought into the Front Surgery by a policeman, who said that he had been called into a Salvation Army Rest Hut in Blackfriars Road to see a man there, who stated that he (the patient) had swallowed 5 three-inch French nails. The story was disbelieved, but as the man looked extremely ill, he was brought to Hospital.

On X-ray examination four nails were discovered—one was seen lying obliquely in the thorax, to the right of the mid-line, with the point apparently projecting about a quarter of an inch into the trachea, and the head apparently lodged in the right bronchus. A second was discovered lying among the coils of the small intestine, a third was at the hepatic flexure. The latter appeared to be firmly fixed, and it was thought it might have perforated the liver. A fourth nail was travelling point downwards in the descending colon, and the fifth had apparently been passed as it was not found.

History regarding the ingestion of the nails, subsequently obtained from the patient himself disclosed the following facts. He resides at Chatham, and has been unemployed for some time past. He wished to obtain money to come to London and seek employment. On the evening of 6th April, 1922, he fell in with two strangers, who produced the nails and wagered him £1 he would not swallow them. He managed four readily, but had some difficulty with the fifth—which brought on a paroxysm of coughing—this nail was in all probability the one found in the right bronchus. The strangers decamped without paying the wager. The patient then went home, but spent a restless night, owing to fits of coughing. The following morning (the 7th April, 1922) he set out to walk to London, and arrived on the afternoon of 8th April, 1922. He was now suffering from giddiness, and the coughing had increased. He slept in a cart that night, and the following day he wandered round the Blackfriars Road until he went to the Salvation Army, from which he was brought to Guy's. He has no recollection of passing a nail during this period.

The walking feat two days after swallowing the nails is all the more remarkable as the patient has a greatly atrophied right leg—the result of suffering from anterior poliomyelitis from the age of 2, for which he was treated at St. Bartholomew's Hospital.

On admission, temperature 101°; pulse 100; respiration 34; and the patient's condition was rapidly

becoming worse. Mr. Bromley was called down, and saw the patient at 11 p.m. on 9th April, 1922. Abdominal examination showed no signs of perforation, *e.g.*, rigidity—although there was great tenderness on deep palpation all over the abdomen. At the time, it seemed extremely probable that one of the nails would perforate the gut, and call for an immediate laparotomy. In view of this contingency arising Mr. Bromley decided to prepare the patient as far as possible, by removing the nail from the thorax. The objects of this were:—

1. To prevent the onset of septic broncho pneumonia, if possible, by removing the septic focus. Had this condition developed the patient would not have been in a fit state to stand an anæsthetic for the closing of the perforation.

2. To remove the source of irritation in the trachea, causing the continual cough, which would have gravely impeded the healing of the laparotomy incision.

Mr. Layton had been called up the same evening—and he decided, that as the abdominal condition did not call for immediate operation he would not attempt to remove the nail in the thorax without the assistance of a staff anæsthetist, adequate instruments, and without the patient on the X-ray table undergoing screen examination to determine the relative position of his instruments and the nail.

Mr. Bromley having decided to operate, performed a low tracheotomy at 12.15 a.m. on 10th April, 1922, and an attempt was made to extract the nail by means of forceps, through this wound. Unfortunately the operation proved unsuccessful. At 10 a.m. the same morning (10th April, 1922) the patient was given an enema and passed one nail per rectum.

At 11 a.m. the same day Mr. Layton saw the patient and decided to attempt to remove the nail from the right bronchus.

The operation was performed at 4 p.m. A broncho-anæsthetic (C. and E. and E.) was administered with the patient lying on the X-ray table. A bronchoscope was was passed, and the anæsthetic continued by means of a narow tube passing down the bronchoscope. After some manipulation the end of the bronchoscope was seen, by means of the screen, to be encircling the tip of the nail, the point of which was about 1 inch below the bifurcation of the trachea. A long-handled forceps was then passed down the bronchoscope, and after several attempts the nail was caught and removed.

A screen examination was then performed on the abdomen and the remaining two nails seen, one at the hepatic flexure, and the other in the descending colon.

The following day, 11th April, 1922, the patient's temperature was 102°, and his pulse and respiration rates were high. Dr. Hunt was asked to see the patient and he thought a septic broncho-pneumonia was starting. Allyl sulphide was prescribed.

On 12th April, 1922, patient was still in a serious condition, but on the following day he commenced to improve. The tracheotomy wound healed, and he maintained the improvement.

On 13th April, 1922, he was again X-rayed—and the report stated that the two nails were lying with long axes parallel, deeply behind symphisis pubes—cannot be affected by palpation—probably in rectum. No other foreign body present.

The last two nails were removed per rectum by Spencer Wells Forceps. The patient has quite recovered and has now been discharged.

I am indebted to Mr. Rowlands, Mr. Layton and Mr. Bromley for their permission to make notes on this case. G. D. S.

Specialities.

"ACOUSTIQUE" ELECTRICAL AIDS FOR THE DEAF.

Mr. R. H. Dent, 95, Wigmore Street, W.1.

This electrical apparatus, which is made on the telephone principle of many similar instruments, is by far the best we have seen, and may be safely recommended as a most valuable aid to people suffering from deafness.

These instruments are so constructed that all metallic sound has been eliminated, and the listener hears the natural voice of the speaker as well as anyone with normal hearing.

The merits of the "Acoustique" have already been widely recognised by Medical Men of the highest standing in the Profession, which is sufficient testimony to its value.

Mr. R. H. Dent is to be congratulated in having applied the principle of the "Acoustique" with equal success, to Stethoscopes for Medical Men afflicted with deafness.

The "Acoustique" is made in 22 different types, so that every user has this instrument attuned to his requirements. The prices range from 6 guineas to 20 guineas.

Mr. R. H. Dent will always be pleased to forward full details to Medical Men on application.

J. F. Rowley, Ltd., Queen Mary's Hospital, Roehampton House Roehampton, S.W.15

Makers of the "Rowley" Artificial Leg.

The name "Roehampton House" brings back vivid memories of the Great War.

It was in 1915 that this Residence was generously given up, and opened by H.M. the Queen, as a

Hospital for soldiers who had been maimed in fighting for their country.

At this time we, as a nation, were forced to consider the question of supply, and the possibility of obtaining the very best product of modern times for our men, and with this object the Government organised an International Exhibition of Artificial Limbs in July, 1915, at Queen Mary's Hospital, Roehampton.

A Board consisting of the leading Orthopædic Surgeons of Great Britain and Ireland was appointed to examine and report on the artificial legs, and after most careful investigation, awarded the only Gold Medal for Artificial Legs to Messrs. Rowley, Ltd.

This Firm then took up their Headquarters at Roehampton House, and ever since, have carried on their extensive work for H.M. Government, the Governments of Canada, South Africa, Australia and New Zealand, and have given physical relief and comfort to thousands of sufferers.

We may mention that they supply a very "Light Metal Limb," that is specially recommended to those who have had an amputation through the middle or upper third of the thigh, or a disarticulation at the hip joint, involving the entire loss of the limb.

This "Light Metal Limb" provides the patient with a limb that calls forth the minimum of effort (with a relative absence of fatigue) from the wearer.

Messrs. Rowley have a staff comprising expert advisers and fitters, and it may be safely said that there is no Firm on whom Surgeons may rely with more confidence for the fulfilment of their instructions.

The University of London Sports.

The above Sports were held at Queen's Club on Saturday, May 27th. We succeeded in regaining possession of the Rosebery Cup after losing it to University College last year. C. L. Steyn, who played a great part in our victory, gained a number of cups, the name of which the writer could not commit to memory, so many and varied were they.

C. L. Steyn performed the remarkable feat of running in and getting first in 100 yards heats, 100 yards final, 220 yards, 440 yards heats and 440 yards final, and also winning the long jump.

Another splendid win was registered by the Tug-of-War Team, who had to be beneath the quite absurd weight limit of 88 stone.

The efforts of T. Wooldridge and F. R. Taylor, who got first in throwing the javelin and second in throwing the discus, respectively, deserve great praise. Owing to some mismanagement of the affair, we had no intimation that these two events would be decided previous to the actual Sports, until about two hours before they were due to come off, when a message arrived at Honor Oak during our own Sports to ask if we wished to send any competitors. Wooldridge and Taylor very sportingly consented to go, so they were put in a taxi and rushed off to Perivale. They arrived there to find all the slim and graceful Javelin and Discus throwers attired in their spotless white and purple robes. But they were not dismayed by such trivial matters as these. They removed their coats, colours, boots and—so rumour has it—their trousers too. So attired in their Aertex "cellular" only—à la Roman Gladiators—they proceeded to moisten their horny palms in the approved Borough manner, as a result of which proceeding Wooldridge succeeded in throwing the Javelin about twenty feet further than anybody else, and Taylor got a very good second with the Discus. Since we only won the cup by three points, these famous performances had a very great value.

The Annual Athletic Sports.

The Hospital Sports were held at Honor Oak Park on Tuesday, May 23rd. The weather was lovely, although perhaps a little hot for those amazing people who pursue the delightful hobby of trotting round the track twelve times. This year they appeared to have come to a mutual agreement not to hurry about it, and who blames them under the circumstances?

The attendance was only fairly good, but those who were there certainly saw some splendid performances and well-contested events. The great feature of the afternoon was the remarkable performance of C. L. Steyn. He broke the Hospital Records for the 220 yards and the Long Jump, both of which were set up by him last year, and, starting from scratch in the 100 yards handicap he won in 10 seconds, so beating the record of 10 1-5 seconds, set up by H. W. Evans in 1911. Two more records were registered, A. S. Gough getting 5 1-5 seconds inside his own record of last year for the half-mile, and P. K. Albertijn putting the shot six inches further than the previous best set up by A. L. Stokes in 1910.

The H.O.P. Coronation Scurry Stakes did not prove so popular as in previous years, but some very good racing was seen and W. F. Roper,

mounted on what appeared to be a very promising twelve-year-old, very cleverly succeeded in finishing first in the Final.

Mrs. Barber very charmingly presented the prizes to Steyn and a few others and so ended a very successful afternoon.

The officials who so kindly assisted were:—

Judges.—Messrs. L. Bromley, E. C. Hughes, W. K. Fry, T. B. Johnston, R. P. Rowlands, F. J. Steward, and Drs. H. S. French and H. A. Monro.

Referee.—Dr. J. Fawcett.

Starter.—Mr. E. J. Holt.

Timekeepers.—Messrs. D. Fowler Dixon and W. H. Brooker.

Details—

100 *Yards Scratch.*—C. L. Steyn, 1; G. K. Lacey, 2; —. King-Turner, 3. Time, 10 2-5 secs.

880 *Yards Scratch.*—A. S. Gough, 1; J. L. Faull, 2. Time, 2m ins. 5 1-5 secs.

100 *Yards Handicap.*—C. L. Steyn (scr.), 1; G. K. Lacey (7 yds.), 2; W. Leslie (7 yds.), 3. Time, 10 secs.

440 *Yards Handicap.*—W. S. Hunt (25 yds.), 1; W. Orsmond (30 yds.), 2; D. S. Todd-White (35 yds.), 3. Time, 51 4-5 secs.

High Jump.—W. J. Badenhorst, 5ft. 4in., 1; —. King-Turner, 5ft. 3in., 2.

Long Jump.—C. L. Steyn, 22ft. 5in., 1.

One Mile.—C. L. Gross (250 yds.), 1; D. E. Ettles (250 yds.), 2; E. Orsmond (200 yds.) 3. Time, 4 mins. 12-1-5 secs.

220 *Yards Handicap.*—G. K. Lacey (14 yds.), 1; A. S. Gough (14 yds.), 2; H. Lewis-Phillips (16 yds.), 3. Time, 22 1-5 secs.

120 *Yards Hurdles.*—P. K. Albertijn (owed 10 yds.), 1; W. Leslie (owed 5 yds.), 2. Time 18 1-5 secs.

220 *Yards Scratch.*—C. L. Steyn, 1; G. K. Lacey, 2. Time, 22 1-5 secs.

Three Miles.—J. L. Faull. Time, 16 mins. 50 secs.

Putting the Shot.—F. G. Hutchinson, 34ft. 11ins. 1

Tug-of-War.—Dentals beat Second Year Men.

Swimming Club.

The Annual Gala of the United Hospitals Swimming Club with its attendant Cup finals is at hand, and, owing to the courtesy of the Committee of the Bath Club, is to be held again in the Swimming Hall of the Bath Club. Up to date Guy's are well in the running for the Inter-Hospital Diving, Swimming and Water Polo Cups. We defeated Bart.'s in the first round in all three events and every day sees us improved.

It can safely be promised that the evening's fare on the 28th June will give the fullest pleasure to all whose good taste and luck lead them to attend the Hospitals' swimming function of the year. The word "luck" is advisedly used, because the number of tickets is very limited and many applications for admittance to last year's Gala were refused on this account.

This year the demand for tickets is sure to be even greater and we would warn all those who wish to attend the Gala that early application is essential.

The best and easiest way for swimmers to ensure obtaining seats is to enter for one of the handicap events, and in view of the fair chance held by every competitor, we urge that all who can, will support the Gala in this manner.

The attendance at last year's Gala, of large numbers of members of the staffs of the teaching hospitals set an example that was worthily followed by members of the Hospital Clubs, and it is to be hoped that this ideal response will be again in evidence on June 28th. Entries for the handicap events close on Monday, the 12th inst., at noon, All applications for tickets should be made to the Hon. Secretary.

The following fixtures have been swum off:—

GUY'S v. UNIVERSITY COLLEGE, LONDON.

This match was played on May 25th, at the Central Y.M.C.A. Baths, and resulted in a victory for Guy's. The score was 3 goals against 1.

Scorers for Guy's—Harvey, Cohen and Brown.

Guy's Team.—Sampson, Simons, Harvey, Hutchinson, Cohen, Brown, Marsh.

GUY'S v. MARCIANS.

On May 26th, at Pitfield Street Baths, the Marcians won in both departments. Lack of combination and erratic shooting were noticeable features of our play, and the racing men do not seem to place much reliance on training.

GUY'S v. MARCIANS.

On May 30th, at Walham Green, our return with Marcians proved more fortunate for the Polo team. The Marcians did not field as strong a side as before and we defeated them by 2 goals to nil.

Scorers for Guy's.—Dingle and Cohen.

The Swimming team was weakened by the absence of Schofield and Bekker, but Theis swam well in the 100 yards.

Guy's Swimming Team.—Hutchinson, Harvey, Marsh, Dingle, Theis, Cohen, Richards, Brown.

Polo Team.—Sampson, Wakeford, Harvey, Hutchinson, Cohen, Dingle, Theis.

GUY'S v. ST. BART.'S.

Inter-Hospital Cups.

Guy's met St. Bart.'s at Fitzroy Baths on June 1st, in the first round for the Hospital Cups.

Diving Cup.

Marsh and Cohen of Guy's easily gained first and second places respectively.

Scores.—Guy's 8, Bart.'s 2.

Swimming Cup.

One Length.—Guy's first and fourth (Bekker and Schofield), Bart.'s second and third.

Score.—Guy's 5, Bart.'s 5. Bekker swam well.

Two Lengths.—Guy's First and second (Hutchinson and Marsh).

Score.—Guy's 8, Bart.'s 2.

100 *Yards.*—Guy's first and fourth (Theis and Brown).

Score.—Guy's 5, Bart.'s 5.

Theis showed evidence of having trained well.

Team Race.—Bart.'s won by nine yards.

Score.—Bart.'s 10, Guy's 5.

Guy's Team.—Schofield, Bekker, Richards, Dingle, Marsh, Hutchinson.

Total score for Swimming Cup.—Guy's 23, Bart.'s 22.

Water Polo.

Guy's won 7—1. The match showed an overwhelming superiority for Guy's.

Scorers for Guy's.—Brown 3, Cohen 3, Hutchinson 1.

Guy's Team.—Sampson, Wakeford, Harvey, Hutchinson, Cohen, Brown, Theis.

GUY'S v. OLD BLUES.

On June 1st, at Lambeth Baths.

Team Race.—Old Blues won after an exciting struggle. Harvey swam well.

Guy's Team.—Harvey, Hutchinson, Marsh, Dingle.

Polo.—Guy's won, 5—0. The team showed great improvement. Brown played exceptionally well.

Scorers for Guy's.—Brown 2, Hutchinson 2, Harvey 1.

Guy's Team.—Sampson, Harvey, Wakeford, Hutchinson, Cohen, Brown, Dingle.

SUMMARY OF SCORING.

	Played.	Won.	Lost.
Diving Matches	2	1	1
Swimming Matches ...	6	3	3
Water Polo Matches ...	8	6	2

Inter-Hospital Boat Race.

The Annual race for the Inter-Hospital Cup will be rowed next Wednesday, June 14th, from Putney Bridge to Hammersmith Bridge, starting at 5 p.m. This year we have also challenged other Hospitals to contest a 2nd IV. race, to be held on the same day.

Arrangements have been made for a steam launch to call for spectators at the Old Swan Pier, London Bridge, at 3.45 p.m., and at Westminster Pier at 4.10 p.m. The launch will then proceed to Putney, follow the race, and return to Westminster Pier. Tickets, price 3s., are limited, and may be obtained from F. C. Miller or R. S. Chambers.

St. Thomas' having scratched, St. Bart.'s and Guy's are the only entrants. Both Hospitals have a better four than last year, and an exciting race should result. A crowd on the tow-path will be most encouraging.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Birth.

PRITCHARD.—At 12, Holroyd Road, Putney, on May 21st, 1922, to Isobel (née McAlpin), wife of G. B. Pritchard, a son.

Marriage.

CARLILL—GODFREY.—On June 3rd, 1922, at St. Margaret's Westminster, by Canon W. H. Carnegie and the Chaplain of the Westminster Hospital, Hildred Carlill, M.D., Cantab., 146, Harley Street, elder son of the late Mr. and Mrs. Stephen Carlill, of 7, Hanover Terrace, Regent's Park, to Mildred Constance Godfrey, younger daughter of Mr. and Mrs. Henry Godfrey, 34, Hertford St., Mayfair.

Death.

BAXTER.—On June 4th, 1922, at Longford, Maryland Road, Bowes Park, London, Joyce Ethel, eldest daughter of Mr. and Mrs. C. W. Woolloton Baxter, in her fourth year.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

ALL at the Hospital will join in extending a cordial welcome to our President, the Prince of Wales, on his return from his tour.

Strenuous as his labours have been during the past few months, His Royal Highness has nevertheless maintained his interest in the welfare of the Hospitals, and on the initiation of the Hospitals' Combined Appeal he cabled his approval of the scheme from the Far East, wishing it success and urging all to support it.

As the President of the King Edward's Hospital Fund he will doubtless have much to do with schemes for the improvement of hospital financial conditions now that he is back in England.

For the present, however, we join with the rest of the country in expressing the hope that he will enjoy a thoroughly good holiday after his exertions.

THE Annual Distribution of Prizes will take place in the Physiological Theatre, on Monday, June 26th, at 3 p.m.

It does not seem likely now that there will ever be a departure from the precedent established two years ago, when this function was treated for the first time as a prize-giving *per se*, and not as a peg whereon to hang a garden party. This innovation has been successful, in that it has made the distribution of prizes a simpler and less formal event, without precluding the possibility of reviving separately the Annual Garden Party of pre-war days.

Unfortunately the Prize Distribution last year was poorly attended. It is to be hoped that there will be a great improvement this year.

There are many men who (possibly with vague reminiscences of war-like activities under the eye of the Regimental Serjeant-Major) regard anything in the nature of a ceremonial parade with the utmost abhorrence. The present order of things should appeal to these. The proceedings will be of a purely private nature, attended only by Hospital men. We hope that there will be a good number of men present.

Viscount Goschen will be in the chair. Sir William Hale-White has undertaken the duty of presenting the prizes, and will address the successful candidates.

This ceremony, simple and informal as it is, is one which Guy's students should endeavour to attend. The few speeches which are made on the occasion of the Annual Prize-giving are generally directed towards an inculcation of that spirit which in the past has been responsible for the fine traditions of this

Hospital, and there can be few, however sophisticated, who do not glean some consolation or derive some inspiration from the words of those who have preceded them.

THE week has been a most successful one for the Hospital from the point of view of athletics. In the first place we are able to congratulate the Athletic Team on restoring the Inter-hospital Shield to the College Smoking Room. Our success was largely due to the very fine performance of C. L. Steyn, who won four events and, in addition, gave our team a substantial lead in the relay race. This performance places him in the unique position of being the only man who has ever, in the history of the Inter-hospital Sports, won four events on two separate occasions. It will be remembered that he succeeded in winning the same four events in 1920.

The records of the Inter-hospital Meeting show that four events have been won by a single person, upon six occasions. On four out of the six a Guy's man was the winner. G. R. Nunn, in 1867, and H. T. Bell, in 1893, are Steyn's two predecessors.

THE boat-races against St. Bartholomew's were both won by Guy's. It was unfortunate that in the junior race a "crab" should have spoilt what promised to be a very fine finish. The senior race went to Guy's easily by 3½ lengths.

Our marksmen still have a fair chance of retaining the Armitage Cup; the cricket team have once more begun well by winning the 2nd round of the Inter-hospital Cup; while the nurses, not to be outdone by the men in their keenness on inter-hospital competition, have beaten, by a comfortable margin, the Grove Hospital, Tooting, in the 3rd round of the Inter-hospital Competition organised by the *Nursing Times*.

WE are asked to remind our readers of the fête which is to be held in the Hospital grounds on Thursday, June 29th.

In addition to stalls for the sale of every conceivable kind of article, and various side shows, there will be dancing in the Nurses' Home, and we hear that the Secretary of the Tennis Club is organising a Ping-Pong competition!

We have already drawn attention to the benevolent activities of the Guy's Hospital Ladies' Association, which is responsible for the fête. We wish this enterprise the success it deserves.

IT is with great pleasure that we congratulate Mr. F. W. Widgery upon winning the Treasurer's Gold Medal for Clinical Surgery.

WE are very glad to hear that a Guy's man has been elected President of the University Union Society. We offer Mr. Toussaint our sincere congratulations upon his election to this honour.

WE have received from the Education Officer of the London County Council, copies of letters and other documents dealing with the efforts made by the London schools on behalf of the hospitals. The Council is as a rule reluctant to allow collections in schools, but representatives of the teaching profession and of London schools of all types have advised the Council that the schools are anxious to renew their efforts to help the hospitals. The Prince of Wales has drawn special attention to the magnificent effort made by school teachers and children in London during 1920, when more than £22,000 was collected for the hospitals. The Prince, whose sympathy with London hospitals has always been of the greatest, now calls for yet another effort, and the correspondence which we have before us deals with the steps which are being taken to organise a further appeal.

The medical and teaching professions have much in common. Both are essential to the welfare of the State, and the activities of both are directed to the establishment of health, whether physical or mental. The help which those who follow the latter calling have given to the hospitals deserves the highest praise. The hospitals of London will appreciate very much this further effort on their behalf, made by London's teachers and London's children.

In connection with the notices concerning applications for appointments, which appear on page 263, it will be seen that these applications should have been sent to the Treasurer, at the Superintendent's Office, not later that June 23rd, 1922—the day before publication of this issue.

We are asked to announce, however, that the applications of those who read these notices, and are desirous of applying for one of the appointments specified, will be considered provided that they are sent in immediately.

We publish in this issue a letter from the Managers and Secretary of the "Beggars' Dances," announcing that more of these dances will be held during the coming winter, and outlining the season's programme.

There can not be many dancing men at the Hospital who did not attend one or more of the dances which have already been held. The "Beggars' Dance" Committee claims, with reason, that the success of the past season justifies a resumption of the dances, at frequent intervals, during the winter of 1922–23, and we feel sure that their plans will suffer from no lack of support.

In arranging these dances the Committee have succeeded in a difficult task—they have managed a series of dances which, although not beyond the means of the average student, present none of the disadvantages of the usual cheap dance. The music and catering of the past dances undoubtedly met with the approval of those who went to them. This year the additional merit of greater accessibility has been secured. Haymarket is a more convenient *venue* than Knightsbridge.

Though not officially connected with the Hospital, these dances are almost entirely attended by Hospital men, and a percentage of the profits is given to the Hospital funds. We hear that the amount so donated, as a result of the past winter's efforts, was £27 6s.

We offer our hearty congratulations to Dr. Barber on his election as a Fellow of the Royal College of Physicians.

The Hospitals' Appeal Committee is still prosecuting its campaign with the utmost vigour. In addition to the methods with which we are all familiar, such as Flag Days, collections, and entertainments of various sorts, the Committee has adopted the plan of sending out a printed appeal, to which is attached a donation form. A copy of this appeal is being issued with each copy of the Gazette this week, and our readers will find, in it, an indication of the lines along which the Committee is working. There are still various ways in which students can assist. In particular we would mention the ball which is to be held at the Albert Hall.

We are asked to draw attention to the fact that a Grand Matinée organised by Lady Tree for the benefit of the Hospitals of London Combined Appeal, is to be held at Wyndham's Theatre, on Tuesday, June 27th, at 3 p.m. Many distinguished artistes are generously giving their services. Further details as to the Matinée will be found on the posters in the Colonnade.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

University of London Debating Society.

SIR,—The Committee for 1920—21, in considering the future of this Society, unanimously agreed that it was highly desirable that the University Union should, in spite of its present membership basis, endeavour to find some plan whereby it could take over completely its functions. There were many reasons for this view, the chief being that our organisation was of necessity exceedingly cumbersome, and further so long as we had to travel from College to College, no effective tradition could ever be built up, no great success could ever be achieved. Hence activities have been held up this Session in order to review the attitude of the Union to Debating in the University.

The Union has regularly invited our members to take a full part in all its debates. But such invitations could only be issued at the discretion of the Committee, and feeling the necessity for some permanent arrangement, a meeting of the Presidents and Secretaries of both Societies (attended also by Mr. B .I. Evans) was held to discuss the possibilities of this. The following motion was framed, and was later agreed to by the Union Committee:—

"That the University of London Union undertakes to summon such members of the University of London Debating Society (not being members of the Union) who attended any debate of the Union to a meeting this Session to discuss future arrangements for Debates for non-members of the Union."

In view of this, the Committee for the present Session unanimously decided that it would recommend dissolution of the Society, if the Union could propose some satisfactory plan as the result of this meeting. It was also unanimously agreed that it would consider as satisfactory any arrangement whereby the Union would make provision for such non-members as are eligible for membership, to take full part in all its Debates and in any discussion affecting its debating activities, on payment to the Union of a reasonable individual subscription.

The Union will notify the date of the meeting it has arranged to summon, in due course.—Yours faithfully,

FRANK W. CREWS,
Hon. Secretary.

Birth Control Conference in London.

SIR,—Up to the present the question of family limitation has not received the attention which it merits from the medical profession. Almost all medical practitioners will agree that some form of birth control is justifiable, and even desirable, under certain conditions; but so far they have devoted little care to the subject, and especially to the consideration and improvement of contraceptive technique.

An international conference dealing with the various aspects of the subject will be held in London next July, 11th to 14th. Friday, July 14th, will be devoted to the medical and contraceptive sections, the latter of which will be open only to medical practitioners and students. The fee for membership of the conference is 10s., but medical men and women can become honorary members by applying to the medical secretary. Any of them willing to contribute papers are invited to communicate with us. The presidents of the other sections are: Professor MacBride (eugenics); Mr. J. M. Keynes (economics); Mr. Harold Cox (national and international aspects); and the Rev. Gordon Lang (moral and religious aspects.—We are, Sir, Yours faithfully,

G. ARCHDALL REID,
President, Medical Section.

NORMAN HAIRE,
President, Contraceptive Sec.

B. DUNLOP,
Medical Section.

71, Harley Street, W.1.

Beggars' Dances.

DEAR SIR,—Owing to the splendid support which the Beggars' Dances received last winter, and in appreciation of that fact, it has been decided to run them fortnightly from October to the end of April. An attempt is being made to improve the dances in every possible way, according to our creed of supplying as much as possible for as little as possible. The dances are to be held at the Suffolk Galleries, Haymarket. There will be a big Christmas gala night on December 19th in addition to one at the end of the season. Double tickets are 8s. 6d., to include buffet refreshments. Ices and drinks are exclusive. Gala nights are 16s. double. It is proposed to run an alcoholic bar at very reasonable prices, which it is to be hoped is another improvement. The band is the stalward Cosmopolitan Five. There is a limited number of season tickets at £3 3s. each which will admit the holder to *all* the dances, both gala and otherwise. Up to July 31st these may be obtained at £3 3s. to give early comers the benefit at this rate, but after that date, if any be left, they will be £4 4s. More detailed announcements will appear shortly.—Yours faithfully,

C. H. EDNEY,
Gen. Org. Sec.

A. S. M. DOUGLAS,
Business Manager.

H. E. EDNEY,
Treas. and Asst. Sec.

H. J. WHITE,
Asst. Manager,

Guy's Hospital, S.E.1.
20th June, 1922.

Cavendish Lecture on the Dural Endotheliomas.

In delivering the Cavendish Lecture at a meeting of the West London Medico-Chirurgical Society on June 15th, Dr. Harvey Cushing prefaced his remarks by a graceful tribute to the memory of Cavendish, adding that in all probability, however, no subject was less remote from the mind of Cavendish than the surgery of the intracranial tumour.

Neurological surgery, that youngest product of modern-day specialisation had grown so rapidly that he felt that the operator was apt to lose sight of the essential pathology of those lesions which he was called upon to treat, and was in danger of devoting too little attention to the study of their genesis.

He believed, therefore, that from time to time the surgeon should pause and critically survey his work and results, and with this purpose to proposed to consider those most hopeful of tumours, the dural endotheliomas, particularly regarding their source and favoured sites of origin.

In his own hospital—the Peter Bent Brigham—the cases admitted for treatment and investigation were divided into three classes :—

1. Tumours verified, when the diagnosis had been confirmed and the type of tumour identified by histological examination of tissue secured either at operation or autopsy.

2. Tumours unverified when, though not histologically confirmed, the diagnosis was almost unquestionable.

3. Tumours suspect, when the diagnosis was likely.

In an analysis of a large number of tumours it was found that the gliomas accounted for 41 per cent. of the total number, the pituitary tumours for 21 per cent., and the endotheliomas for 11 per cent.

The time, however, the speaker considered was long since past when any useful information was to be derived from any such cursory consideration, and in view of the protean nature of the intracranial tumour the only hope lay in the subjection of one or other type to a critical examination. The investigator, proceeding on such lines, might, on the one hand, consider those tumours identical in structure, disregarding their situation; or he might, on the other hand, consider those of identical situation, disregarding their structure, or he might, alternatively limit his investigation by devoting his attention to those of a single type occurring in a given situation.

In discussing the dural endotheliomas it was not considered desirable to include the acoustic neuromas, although brief mention was made of them in passing. These tumours arose close to the internal auditory meatus, and although in a few of the very rare cases in which the tumour was bilateral, numerous small endotheliomas were found in other situations, there was no doubt in the speaker's opinion that these tumours differed entirely in their origin.

Following a very complete historical review of the dural endotheliomas—or, as Dr. Cushing preferred, the meningiomas—it was pointed out that until a few years ago these tumours were considered of dural origin, although, in point of fact, they undoubtedly had their origin in the arachnoid. This fact was known by Cleland, of Glasgow, almost fifty years ago, although it did not become generally known until the investigation by Weed of the cerebro-spinal circulation.

Notwithstanding the confusion as to the histology of these tumours, however, the macroscopic appearances and prevalent situations were well recognised, and were figured by Cruhveillier in his pathological atlas in 1829.

When the true origin of these tumours, therefore, had become widely recognised, it followed that the term dural endothelioma was, strictly speaking, a misnomer, and of the alternatives suggested meningioma seemed the most suitable, being less cumbersome than the more precise meningo-endothelioma.

The characteristic feature of these tumours, continued the speaker, was the presence within them of certain cell nests whose origin had been the subject of much research.

Weed, in his studies of the cerebro-spinal circulation found that these cells constantly were present in arachnoid villi, which project into the venous sinuses of the skull and afford thereby a passage for the exit of the cerebro-spinal fluid.

Their function would appear to be phagocytic, for on injecting the subarachnoid space of an animal with lamp black it was constantly found that these cells had greatly increased in number and contained large quantities of pigment.

The function of the villi was of extreme importance in maintaining the normal pressure of the cerebro-spinal circulation, and it was important to realise the ease with which these paths of emergence became blocked.

The speaker here mentioned the way in which the cell débris of an intracranial operation tended to occlude the villi, with the effect that in many cases the intracranial pressure after operation frequently rose, a difficulty of grave consequence and one which was constantly encountered in the work of the neurological surgeon.

Whatever the connection between these cell nests and the origin of the meningiomas, there seemed to be no doubt whatever that trauma was a factor

of outstanding importance, and in more than half the number of the series of cases under discussion the situation of the tumour accurately corresponded to the site of some previous trauma which in many cases had left some permanent evidence of its infliction.

Regarding the site of the meningiomas, it was evident that they always arose in close connection with one of the cerebral sinuses, although in some cases the tumour became pedunculated as growth advanced and its mass became hidden in the substance of the hemispheres or occasionally between them.

It was noted at this point that the last-mentioned possibility should always be born in mind, for in this situation they were very liable to be overlooked by the usual lateral approach through an osteoplastic flap. In those cases in which the tumour lay between the upper part of both pre-central gyri, the clinical picture was one of focal epilepsy, affecting one or both feet, but such a picture was relatively uncommon.

The meningiomas differed widely in their size, shape, and contour. They weighed, in extreme instances, as much as 250 grms., and it was interesting to note that the largest of tumours were often impossible to localise. The tumour was sometimes smooth and sometimes lobulated, sometimes sessile and sometimes pedunculated; in the base of the brain they were often of the "plaque" type, widely involving the basal nerves. A diagram of one such tumour was shown where the growth began in Meckel's cave. The clinical picture was predominated by a trigeminal anæsthesia, and the case was thought to be one of a simple small Gasserian endothelioma. On operation it was found to be both extensive and irremovable.

In general it was found that the meningiomas were much more common in the anterior and middle cranial fossæ than they were in the posterior fossa, and of a series of 87 cases, only 2 were occipital in situation. The following situations were commonly affected :—

1. The cavernous sinus.
2. The olefactory groove.
3. The lateral sinus.
4. The superior longitudinal sinus.

5. The falx cerebri, where it was noted that the meningiomas tended to become pedunculated.

It had been noticed a number of years ago that the brain on removal intact with its membranes tended to bulge at certain definite points especially where the Pacchionian bodies were well marked—over the upper surface of the frontal and parietal lobes. Actually these were minute herniations of the brain substance into the villi of the arachnoid, and it was instructive to notice that these situations corresponded very accurately with those of the meningiomas found in the region.

In the spinal cord these tumours are nearly always found very closely associated with the origin of a spinal nerve, and it was shown by Weed that in this situation the villi above mentioned were constantly present.

In the case of the suprasellar meningiomas, diagnosis was sometimes difficult, and confusion arose with the pituitary adenomas. In the latter, however, the deformity of the sella was usually characteristic, while in the former it sometimes happened that the pressure of the tumour produced a papillœdema on one side and an optic atrophy on the other.

Meningiomas of the cavernous sinus usually were followed by unilateral exophthalmos, and this, with the other evidences of a rising intracranial pressure, was sufficient evidence to localise the tumour.

A series of photographs of patients suffering from meningiomas in this situation were shown to emphasise the constancy of the exophthalmos.

In the case of tumours affecting the vertex, the condition of the bone overlying was sometimes of diagnostic value.

Not uncommonly there was marked hyperostosis and thickening, which though usually limited to the outer table, sometimes involved the inner in addition. Bony atrophy was much less common.

Regarding the other external evidences of these neoplasms it was pointed out that the superficial veins over the affected area were sometimes greatly congested and engorged.

In conclusion, a number of diagrams of the skull were shown with superimposed markings illustrating the situation and relative size of each tumour of the series. A brief account of the osteoplastic method of approach was given, together with a few of the details of its technique. Regarding technique in general, Dr. Cushing concluded that in no other branch of surgery were accuracy of suture and nicety of detail so important and so essential for the relief and future welfare of the patient. G. M.

Change of Address.

F. W. Fawssett, 6, Belgrave Terrace, Chantry Lane, Grimsby.

J. Millard Barnes, L.D.S., 30, Queen Anne St., W.

H. P. Aubrey, L.D.S., 83, Portland Place, W.

A. W. Ormond, C.B.E., F.R.C.S., 9, Devonshire Place, W.

J. V. C. Braithwaite, M.B., B.S., M.R.C.P., 72, London Road, Leicester.

F. R. Wallis, L.D.S., 3, Crawford Gardens, Cliftonville.

Notices.

Hospital and Medical School.

Applications are invited for the following appointments, the duties of all the posts to commence on October 1st, 1922.

Particulars as to honoraria may be obtained on enquiry either in the Superintendent's Office or in the Medical School Office, and applications should be sent to the Treasurer, at the Superintendent's Office, not later that June 23rd.

I.

Tuberculosis Officer	1
Medical Registrars and Tutors	4
Medical Assistants	2
Surgical Registrars Tutors and Assistants ...	3
Obstetric and Gynæcological Registrars	1

II.

Chief Clinical Assistants and Registrars—	
Ophthalmological Department	2
Throat and Ear Department	2
Orthopædic Department	1
Neurological Department	1
Chief Clinical Assistant in—	
Dermatological and V.D. Department ...	1
Genito-Urinary and V.D. Department	1
Children's Diseases Department	1
Actinotherapeutic and Electrical Dept. ...	1
Bacteriological Department (Senior Assistant Bacteriologist)	1
Junior Assistant Bacteriologist	1
Chief Clinical Assistant (Female) to the Obstetric Surgeons V.D. Department	1
Medical Officer (Male) to Female Venereal Clinic	1
Resident Medical Officer, Bright Ward	1
Anæsthetists to the Hospital	2
Anæsthetist to Bright Ward	1
Assistant Anæsthetists to the Hospital	4

III.

			per ann.
Demonstrators of Physiology	2	...	£250
„ „ (part time)	1	...	£100
„ Anatomy	2	...	£250
„ „ (part time)	1	...	£100
„ Pharmacology „	1	...	£100
„ Pathology	1	...	£250
„ „ (part time)	1	...	£100
„ Chemistry (whole time)	2	...	£250
„ „ (part time)	1	...	£100
„ Physics (whole time)	1	...	£250
„ Biology (whole time)	1	...	£250

The attention of applicants is drawn to the fact that appointments are made in the first place for two years.

Applications are invited for the following appointments, duties to commence on October 1st, 1922.

Particulars as to honoraria may be obtained on enquiry either in the Superintendent's Office or in the Medical School Office, and applications should be sent to the Treasurer, at the Superintendent's Office, not later than June 23rd.

Griffiths Demonstrator of Pathology.
Anderson Demonstrator of Clinical Chemistry.

Dental School.

Applications for the following appointments should be sent to the Treasurer, at the Superintendent's Office, not later than June 23rd, 1922.

Resident Dental Officer	1
Dental Radiographer	1
Dental Bacteriological Assistant	1
Demonstrators of Prosthetic Dentistry	2
Demonstrators of Operative Dentistry—morning attendance three times a week, with charge of Probationary Classes and ordinary extractions	4
Demonstrators of Operative Dentistry—afternoon attendance	2
Dental Officer to Salomons Welfare Centre ...	1
Anæsthetist to the Dental Department, Salomons Welfare Centre	1
Assistant Anæsthetist to Dental School—six sessions per week	1

The duties of the above appointments to begin on October 1st, 1922.

Treasurer's Gold Medal.

The Treasurer's Gold Medal for Clinical Surgery has been awarded to Mr. F. W. Widgery.

Beaney Scholarship in Materia Medica.

The Beaney Scholarship in Materia Medica is now vacant. The Scholarship is open to candidates who have received part at least of their Medical education at Guy's Hospital, is of the annual value of about £50, and is tenable for three years. Further particulars may be obtained from the Dean, with whom applications must be lodged, not later than July 7th, 1922.

Gull Studentship.

Applications are invited for the Gull Studentship in Pathology and Allied Subjects, which is now vacant. The Studentship is open to candidates under

35 years of age, who have studied in the Medical School of Guy's Hospital, is of the annual value of about £250, and is tenable for three years. Further particulars may be obtained from the Secretary to the Board of Electors, to whom applications must be addressed at the office of the Medical School, not later than 7th July, 1922.

Metropolitan Asylums Board.

CHILDREN'S SERVICE.

APPOINTMENT OF SENIOR ASSISTANT MEDICAL OFFICER.

The Metropolitan Asylums Board invite applications for Appointment as Senior Assistant Medical Officer in their Children's Hospitals Service for duty at Queen Mary's Hospital for Children, Carshalton, Surrey. The Hospital accommodates 810 children, and there is a staff of five Assistant Medical Officers. A large proportion of the beds are reserved for tubercular cases, especially those requiring surgical treatment. Candidates must be under thirty-five years of age and unmarried, and preference will be given to those who have had previous surgical experience with some experience of administration. Commencing salary including war bonus £645 5s. 0d. per annum, rising (with war bonus at present rate) to £709 13s. 0d. per annum.

The candidate appointed will be required to reside in the Hospital, and to pay for board, lodging, and washing at the rate fixed from time to time by the Board's Finance Committee. At present the rate is £130 per annum.

Applications to be made not later than 10 a.m. on Thursday, 29th June, 1922, on forms obtainable from the Deputy Clerk, Metropolitan Asylums Board, Embankment, London, E.C.4.

G. A. POWELL,
Deputy Clerk to the Board.

June, 1922.

CHILDREN'S SERVICE.

APPOINTMENT OF JUNIOR ASSISTANT MEDICAL OFFICER.

The Metropolitan Asylums Board invite applications for Appointment as Junior Assistant Medical Officer in their Children's Hospitals Service for duty at Queen Mary's Hospital for Children, Carshalton, Surrey. The Hospital accommodates 810 children, and there is a staff of five Assistant Medical Officers. A large proportion of the beds are reserved for tubercular cases, especially those requiring surgical treatment. Candidates must be under thirty-five years of age and unmarried. Salary £515 6s. 0d. per annum (including war bonus).

The candidate appointed will be required to reside in the Hospital, and to pay for board, lodging, and washing at the rate fixed from time to time by the Board's Finance Committee. At present the rate is £130 per annum.

Applications to be made not later than 10 a.m. on Thursday, 29th June, 1922, on forms obtainable from the Deputy Clerk, Metropolitan Asylums Board, Embankment, London, E.C.4.

G. A. POWELL,
Deputy Clerk to the Board.

June, 1922.

Empire Flag Day.

Results as received up to June 13th, 1922.

	£	s.	d.
St. George's Area	2,455	13	1
University College Area	2,721	0	0
Hampstead General Hospital Group ...	1,156	13	1
Royal Northern Hospital Group	2,472	11	3
Willesden Hospital Group...	615	7	5
St. Bartholomew's Hospital Group ...	3,899	14	10
St. Thomas's Hospital Group	2,453	0	8
Greenwich, Lewisham & Deptford Group	965	5	11
Westminster Hospital Group	4,159	17	6
London Hospital Group	2,005	18	5
Guy's Hospital Group	2,463	5	7
Woolwich Area	496	13	8
West London Hospital	1,225	7	9
Middlesex Hospital	2,200	0	0
St. Mary's Hospital	1,458	0	0
King's College Hospital Group—			
Camberwell 919 1 9			
Beckenham 231 14 1			
Bromley 184 2 6			
	1,334	18	4
Richmond Area	644	0	0
Donations received at Headquarters ...	5,401	5	6
	£38,128	13	4

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

A Case of Intestinal Obstruction by a Meckel's Diverticulum in a Child.

CLINICAL LECTURE BY MR. PHILIP TURNER.

GENTLEMEN,—In choosing this subject for to-day's lecture I was influenced by several considerations. For one thing, this case brings before us some of the difficulties so often met with in the diagnosis of abdominal emergencies in children; for another, it enables us to consider the ways in which Meckel's Diverticulum, a structure which may be present in an apparently normal and healthy individual without giving any sign or symptom of its presence, may cause intestinal obstruction; and lastly, because it so happened that, at the same time, I had two other patients in the hospital in whom a diverticulum was unexpectedly found at an operation, though in neither of these had it been the cause of any obstruction. I will first give a full account of the first case and then shortly tell you about the other two.

The patient, a boy aged six years, was admitted on July 8th, 1921, for abdominal pain.

He had been taken ill on the preceding evening. In addition to the abdominal pain, which was general but not severe, he had vomited several times; there was no history of diarrhœa, the bowels having acted normally up to, and on, but not after, the day of the onset of symptoms. When admitted the pulse rate and temperature were normal, and as there was only very slight abdominal tenderness without rigidity or distension, he was for a few hours kept under observation and the pulse rate recorded every half hour. When I saw him in the afternoon the abdomen, though rather full, was not rigid; there was slight tenderness on the right side, but no lump could be felt. A rectal examination revealed nothing abnormal; no blood was noticed and the history was that none had been passed since the onset of the illness. There had, however, been some bilious vomiting on two occasions since his admission. The pulse rate was 80 and the temperature 98.

You will see that there was apparently not very much to go upon, but the following were the more striking features of the case :—1. The sudden onset. 2. The boy looked distinctly ill. 3. The abdominal tenderness which, though slight, must in children never be neglected. 4. The persistent vomiting associated with 5. the fact that the bowels had not acted since the onset. In such a case the first thing to do is to decide whether one is dealing with an abdominal emergency or not. In this particular case, owing to the slightness of the signs, it was not an easy matter to decide, and some who saw the boy thought that he might be suffering from gastritis, the result of having possibly eaten some unsuitable fruit or food. The presence, however, of the above five features made one feel certain that there was some definite lesion calling for operative treatment, and it was decided to open the abdomen as soon as the necessary preparations had been made.

As regards the actual diagnosis, the four following were considered, the last of which was regarded as the most probable—

1. *Intussusception.*—The only point in favour of this was that the boy had signs and symptoms suggestive of obstruction. On the other hand, the absence of any blood per rectum and of any abdominal tumour were decidedly against this diagnosis.

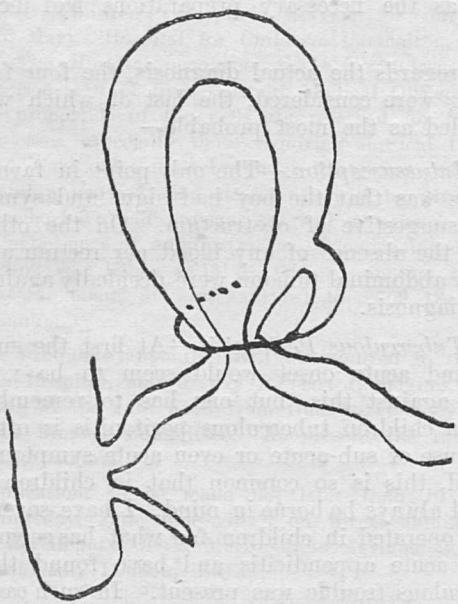
2. *Tuberculous Peritonitis.*—At first the sudden and acute onset would seem to be very much against this, but one has to remember that in children tuberculous peritonitis is often the cause of sub-acute or even acute symptoms. Indeed, this is so common that in children it should always be borne in mind. I have several times operated in children for what has seemed to be acute appendicitis and have found that tuberculous trouble was present. In such cases the tuberculous disease may be most marked and most acute in the region of the appendix so that one may regard these cases as acute tuberculous appendicitis. Sometimes in these cases enlargement of the mesenteric glands may be made out; there was no evidence of this in the present patient.

4. *Appendicitis.*—This was regarded as the most likely diagnosis. It is true that the signs and symptoms were rather anomalous. The pain was not severe, and was apparently generalised over the whole abdomen; the tenderness was, however, more marked on the right side.

An interesting fact was that the last time the pulse rate was taken, shortly before he was moved to the operating theatre, it was

found that it had suddenly risen to 130. This may have been due to the disturbance associated with the preparation, but, on the other hand, it may have been that the abdominal condition was at length beginning to affect the pulse. When the boy was anæsthetised, a vague lump with ill-defined outline could be felt on the right side of the abdomen, and this tended rather to confirm the diagnosis of appendicitis.

The abdomen was opened by a right paramedian incision. This was chosen partly because there was some doubt about the diagnosis, and partly because it was felt that this would give free access and allow satisfactory



drainage of any collection of pus. When the peritoneum was opened, a little clear fluid escaped, and immediately a coil of dilated small intestine, absolutely black in colour, presented through the incision. The coil, when drawn out through the wound, proved to be about 12 inches in length and appeared to be gangrenous. Further examination showed that the coil was part of the lower end of the ileum and that its base was tightly encircled and strangled by a definite fibrous band. This sprang from a Meckel's Diverticulum, encircled both limbs of the loop, and was attached to the mesentery.

The condition is shown in the diagram.

The fibrous band was divided, and it was noticed that there was no escape of fæcal matter and no fæcal odour. While these examinations were being carried out, the colour of the intestine improved, and it was now a very deep crimson. This, of course, showed that the intestine was not actually gangrenous and that there was a prospect of its recovery. Remember that in such a case gangrene is especially likely to occur at the line of constriction so that this should always be carefully scrutinised. Remember, too, that the absence of any foul odour is against gangrene, and also that a piece of intestine may be absolutely black and yet recover; gray or green is much more characteristic of gangrene than black. No evidence of gangrene having been found, the intestine was washed with saline, replaced, and the abdominal wound closed. It was considered inadvisable to remove the diverticulum itself at this operation. In such a case the diverticulum also becomes deeply congested and œdematous, and under these circumstances stitches are apt to cut through or subsequently give way. In some cases the blood supply of the diverticulum is cut off before that of the coil of intestine which it encircles. The diverticulum then becomes gangrenous, sloughs, and releases the intestine; a peritonitis, possibly fatal, is set up and the case is often then regarded as a "diverticulitis" of Meckel's Diverticulum. In the present patient is was decided to leave removal of the diverticulum to a subsequent operation.

The boy made an uninterrupted recovery, was discharged to a convalescent home about three weeks later, and was re-admitted on the 10th October for removal of the diverticulum. The abdomen was again opened, and it was interesting to find that the diverticulum had again become adherent and might quite possibly have been the cause of further trouble. It was found to be about two inches in length, was of about the same diameter as the ileum, to the free border of which it was attached about 20 inches above the ileo-cæcal valve. The bowel was clamped on each side, the diverticulum removed, and the opening in the ileum closed by two layers of sutures. Here again the patient was fortunate, for sometimes the diverticulum is attached asymmetrically or it may be larger in diameter than the distal part of the ileum, or it may be associated with some narrowing of the intestine, in either of which cases it is necessary to excise not only the diverticulum, but also the loop of intestine from which it springs. Again the patient

made a good recovery. I saw him a short time ago and he has had no trouble since.

Before discussing this case further I will briefly mention the two other cases of persistent Meckel's Diverticulum in the hospital at the same time. The first of these was a man aged 40 years. He was admitted for an operation for a right femoral hernia, the only special point about which was that it was irreducible. At the operation, when the sac was opened, it was found to contain a piece of bowel. When this was examined it was found to be a single piece ending blindly, not a coil with an ascending and a descending limb. Gimbernat's ligament was divided, and then on pulling down more intestine it was found that this was a Meckel's Diverticulum completely filling the sac and springing from the free border of the ileum. The diverticulum was removed, and the patient did perfectly well afterwards. A hernial sac containing a Meckel's Diverticulum is known as a Littré's Hernia, and must be distinguished from a Richter's Hernia in which a portion only of the circumference of the intestine enters the hernial sac. Either of these varieties of hernia may become strangulated.

In the third case a Meckel's Diverticulum was found in the course of an exploratory laparotomy in a middle-aged woman for obscure abdominal symptoms. The diverticulum was free in the peritoneal cavity; it had no fibrous cord attached to it, and as it was giving rise to no trouble, it was left alone.

The first point to which I wish to draw your attention, the difficulty so often experienced in the diagnosis of an abdominal emergency in children, is well shown in the first case. Here was a child with acute intestinal obstruction and a foot of intestine on the verge of gangrene, yet the signs and symptoms were so slight that there was some doubt as to whether there was any condition calling for operation at all. Yet I feel sure that a delay of a few hours would have meant that the bowel would have become gangrenous and that the child would then very probably have died. In the following remarks I do not refer to intestinal obstruction alone, but to abdominal emergencies in general, and especially to appendicitis, the most frequent of them all.

It is unfortunately a frequent occurrence—I expect a good many of us are acquainted with such—for a child to be taken ill with some rather vague abdominal trouble, to be operated upon perhaps three or four days later, and then, though the actual operation may have been satisfactory, for the patient to die shortly after. In such cases we are apt to hear that the operation was done too late. True. But why? In the great majority of cases because the diagnosis was made too late. What is the reason for this, and can such mistakes be avoided?

In the first place, the diagnosis so often has to be made without a history, or at least without a reliable history from the patient himself who is too young to give an account of his symptoms. In the present case, for example, all that could be got out of the boy was "that he felt better," and "that he had no pain now."

The next, and perhaps the most important, is that in children the symptoms are often anomalous, or, at any rate, are often very different from those which are usually so characteristic in adults.

Let us, first of all, consider the question of pain. In children the pain is often referred to the umbilical region, to the upper part of the abdomen, or may be diffuse and variable; and what is most deceptive of all, pain and tenderness may be slight and after a time tend temporarily to diminish or even to disappear, thus giving quite a false sense of improvement. In appendicitis in children, though there may be constipation, there is often diarrhœa, and the motions may contain mucus and even blood, suggestive of enteritis or colitis. Another common and misleading symptom is irritation of the bladder with painful and frequent micturition. This is usually explained by saying that in children the bladder is above the pelvic brim and must be regarded as an abdominal organ, but whether this is so or no it often occurs and may even suggest the presence of a vesical calculus.

Our present case shows also that even the pulse-rate and temperature may be misleading. This often happens in children, but the commoner thing is for pulse and temperature, or both to be affected by some comparatively inadequate cause. It will be well to remember that in children the appendix commonly occupies a higher position than in the adult, often immediately below the liver, and also that

the cæcum, and hence the appendix is much more movable. This probably accounts for the unusual situation and character of pain and tenderness and also helps to explain the larger proportion of severe cases of appendicitis with spreading or general peritonitis which occur in children. I think that possibly some of these cases are overlooked for a time owing to the fact that too much attention is directed to searching for pain and tenderness in the right iliac fossa.

From the practical point of view I think that we should always remember the likelihood of anomalous symptoms in these cases, and always regard as serious any abdominal symptoms in children, especially when the onset is acute or sub-acute, and most of all when they are persistent. Always take into account the general condition of the child and the signs and symptoms as a whole. Lastly, if the child looks and seems ill, and there is uncertainty as to the cause of the abdominal symptoms, incline, in a doubtful case, to recommend operation.

I now wish to say something about Meckel's Diverticulum and to consider the role it plays as a cause of surgical abdominal emergencies. As you all know it is a relic of the vitelline duct which, in the fœtus, leads from the midgut to the yolk sac. In the course of development it should completely disappear, but some trace of it persists in a small proportion of individuals and it then may, without warning, and without any evidence of its presence, produce some abdominal emergency in patients, often young and vigorous, and apparently in perfect health.

As regards the frequency of its occurrence, it is known to be present in about $2\frac{1}{4}$ per cent. of all bodies. Mitchell, of Chicago, found 39 examples in 1,635 successive post-mortems, or 2·38 per cent. In most of these, of course, it was found in the course of routine examination and was not the cause of death or of any diseased condition. His investigations show the remarkable and interesting fact that it is more likely to be present in males than females, for, in this series, there were 1,330 males with 35 diverticula, or 2·68 per cent., and 305 females with 4 diverticula, or 1·31 per cent. If cases in which the diverticulum has been responsible for some pathological condition are alone considered this disparity between the sexes would appear to be yet more striking. Thus, some years ago I collected a large number of cases in which a Meckel's Diverticulum was present,* including a series of 48 cases from the Guy's clinical and post-mortem reports, in which the diverticulum was the cause of some definite lesion. Of these 36 were males, 10 females, while in two the sex was not recorded.

From the free end of the diverticulum there will often be found a fibrous cord extending to the umbilicus, or to the mesentery, or some viscus, or ending freely in the peritoneal cavity. This cord, which is of greater importance than the diverticulum itself in causing intestinal obstruction, is formed by the obliterated vitelline vessels. These are three in number, the vitelline artery, the persistent portion of which becomes the superior mesenteric, and two vitelline veins, the left of which disappears while the proximal part of the right persists as the superior mesenteric vein. From these developmental facts it will be seen that, in the fœtus, the diverticulum and the vessels which supply it with blood must be connected with the umbilicus. This original arrangement may persist, but when this is so the troubles which result are likely to be situated at the umbilicus, where there may be a fistula, or a polypoid mass of granulations, or a cyst which may later give trouble by suppurating. Intestinal obstruction is not so likely as when there is an attachment to the mesentery, though it does sometimes occur by a coil of intestine becoming kinked over the band thus formed as it crosses the peritoneal cavity.

The attachment of the fibrous band to the mesentery, which is so often found, is secondary. The explanation is that as the child grows the band becomes torn away from its attachment to the umbilicus, or this may take place as the result of some muscular action. The band is then free in the peritoneum for a time, but, as can easily be understood, the rough, frayed free end will almost certainly become adherent, usually to the mesentery because its surface is largest, but occasionally to the abdominal wall or to any structure or viscus in the abdominal cavity. Wherever it becomes attached an arch will be formed beneath which a coil of intestine may be forced so that a very sudden and acute intestinal obstruction may occur.

Thus Meckel's Diverticulum, as met with clinically, especially in the course of abdominal

*Guy's Hospital Reports, Vol. lx., p. 279.

emergency operations, consists of a finger-like projection from the ileum which represents the proximal part of the vitelline duct of the fœtus. Often there will be a fibrous band extending from the blind end of the diverticulum either crossing the intestine or forming an arch beneath which a coil is tightly gripped and obstructed. While the diverticulum may be present, either alone or with the fibrous band, it must be remembered that sometimes the actual diverticulum disappears, but the band persists and may give rise to obstruction. Such a band, often called "the solitary band," is generally situated near the lower part of the ileum and though not a true Meckel's Diverticulum is derived from the obliterated vessels which supply this structure with blood.

The position of the diverticulum varies to a considerable extent. It is usually situated about two feet above the ileo-cæcal valve, but it may occupy any position between a few inches from the ileo-cæcal valve and fairly high up in the jejeunum. Generally it originates from the free border of the intestine, but is occasionally placed laterally, and may even project from the attached border between the two layers of the mesentery. It has been suggested that some mesenteric cysts may be formed from a diverticulum so placed by the proximal part becoming atrophied, so that the distal part is situated in the mesentery, but has lost all connection with the gut.

We have now to consider the various ways in which a Meckel's Diverticulum may be the cause of intestinal obstruction.

1. It may be the cause of an intussusception. It is well known that sometimes when an intussusception of the ileo-colic variety is reduced that at the apex there is an invaginated diverticulum. Presumably this occurs as the result of some irregular peristalsis and the diverticulum then acts as a foreign body causing forcible peristalsis which forces this structure onwards along the lumen of the intestine and of course draws the bowel from which it springs after it.

2. The diverticulum is provided with a fibrous cord which is attached to the mesentery or to some other structure and thus forms an arch beneath which a coil of intestine is forced and becomes obstructed by the band. This is the commonest way in which obstruction is caused and is the mechanism of the obstruction in the case we have just considered. In these cases it is probable that for a considerable time a portion of the coil has been under the arch without giving rise to any symptoms and then, at last, obstruction is brought about either by an additional length of intestine entering the trap, or possibly by some increased dilatation of the loop already present. Occasionally this condition of a loop of intestine passing beneath the arch but not in a condition of obstruction is found by chance at a post-mortem examination where the patient has died from some other cause. There are two or three of these cases to be found in our post-mortem records. It does not, of course, matter where the distal part of the band is attached and a coil of intestine may become kinked over it even when the primitive attachment to the umbilicus persists.

3. Sometimes only the proximal part of the fibrous band persists, that is the part from the mesentery to the apex of the diverticulum. Under these circumstances the band must cross over the ileum, often binding it down and leading to obstruction by kinking. These cases are more difficult to understand than the last group since the band must have been present for a long time, probably all the patient's life, and yet have given rise to no symptoms. The most probable explanation again is that some unusual dilatation, or possibly some slight injury or muscular effort increases the kink and thus starts the obstruction which is then likely to be increased by the effort of the intestine above to overcome it.

4. A rare but very interesting form of obstruction may occur when a fibrous band, of some length, extends from a diverticulum and ends freely in the abdominal cavity, having broken away from its original attachment to the umbilicus or from some secondary attachment. Such a band may actually become tightly knotted round one or more coils, forming a slip knot in exactly the same way that one might tie a piece of string round the intestine. For this to occur it is essential that the band shall have an enlarged bulbous free extremity. If the end of the band were tapering and a knot were formed it would probably, when it became tightened, just pull through, but when there is a knob at the end it is almost impossible for it to pull through, and again any effort of the intestine to free itself will probably tighten up the knot. The knotting must take place

by chance in the course of the continuous changes in position of the band as it lies freely in the peritoneal cavity. This condition may be very puzzling when met with in the course of an operation, as a considerable amount of the small intestine may be strangled in the knot, which may be remarkably tight.

5. When attached to the umbilicus, the coil from which the diverticulum springs must have its mobility considerably restricted. Under these circumstances a volvulus of the fixed coil may occur. This is a rare cause of obstruction. The fixation need not necessarily be to the umbilicus; a case has been recorded where the fibrous extension from the diverticulum had become secondarily attached to the bladder with the result that obstruction was caused by a volvulus of the fixed coil. Sometimes a free bulbous diverticulum itself becomes twisted at its base, and this may so narrow the lumen of the ileum as to cause obstruction.

6. A Littré's Hernia of the type described above may give rise to obstruction. The symptoms and signs will be indistinguishable from those of an ordinary strangulated hernia.

7. The lumen of the ileum may be considerably diminished at the attachment of the diverticulum and this may determine the impaction of a foreign body and thus cause acute obstruction.

8. It must be remembered that the "solitary band," usually attached to the lower part of the root of the mesentery near the right iliac fossa is probably derived from the fibrous cord formed by the obliterated vitelline vessels though the diverticulum itself has completely disappeared. Obstruction by this band is thus very similar to that described under 2 and 3. Acute obstruction is sometimes caused by a coil of intestine being forced through a hole in the mesentery. The way in which these abnormal apertures in the mesentery arise is often very uncertain, but it has been suggested that some of them at any rate may be due to thinning and absorption of the mesentery to one side of a fibrous cord derived from the obliterated vitelline vessels.

9. A Meckel's Diverticulum may be the explanation of some cases of congenital intestinal atresia, or occlusion of the small intestine. This rare condition is necessarily fatal and it is not necessary to further discuss it here. It may be explained as an excess of the normal process of atrophy of the vitelline duct, extending to the adjoining part of the small intestine.

Of these methods in which a Meckel's Diverticulum can be responsible for intestinal obstruction, the first three are the most important. I have mentioned the others in order to bring to your notice some of the many ways in which the diverticulum can be responsible for obscure acute abdominal emergencies. Two important points remain for our brief consideration. The first is: Can the presence of a Meckel's Diverticulum be diagnosed? I think that it must be admitted that a definite diagnosis is very seldom possible though sometimes its presence may be regarded as likely. For instance, suppose a young and healthy adult, especially a male, with no previous history of appendicitis or other abdominal trouble, has a sudden acute abdominal pain and developes all the symptoms of acute intestinal obstruction. In such a case, in the absence of any obvious cause the presence of a diverticulum may be suspected. These cases are usually too acute to permit of a bismuth and X-ray examination and it is very unlikely that a diverticulum would be shown in this way. I have not heard of one being recognised in the course of a routine examination and Mr. Redding agrees that this method of diagnosis would be of little or no use in ascertaining the presence of a diverticulum.

I can only once claim to have confidently diagnosed the presence of a diverticulum. Here a young man, 25 years of age, was quite suddenly taken ill and showed the typical signs and symptoms of acute obstruction. On going into the history, I found that in infancy he had been treated, apparently successfully, for "patent urachus." From this I felt sure that, in infancy, he had an umbilical fistula due to a diverticulum which had its primitive attachment. The sinus closed after cauterisation, but the diverticulum subsequently broke away, derived a secondary attachment to the mesentery, and formed an arch beneath which a coil of intestine became nipped; this was the condition found at the operation. It might be thought that in such a case of fistula there would be a fæcal discharge. This, however, is often, and indeed usually, not the case. The diverticulum is lined internally by mucous membrane which secretes a clear yellow fluid, similar in character to the succuss entericas, and in appearance closely resembling urine. I do not mean to say that a discharge of urine along a patent urachus at the umbilicus never occurs, but a diverticulum is much more frequent and a his-

tory of such a fistula will occasionally help us to make a definite diagnosis. Though we should always endeavour to diagnose the cause of obstruction before operation it must be realised that in the case of Meckel's Diverticulum this is usually impossible; it is, however, of the greatest importance for us to have a knowledge of how it may cause obstruction in order that we may quickly realise the condition found during an operation and adopt the proper measures for its relief.

The remaining point is to say something about the treatment to be adopted when a diverticulum is present. In an adult patient where, during the course of an operation, a pouch-like diverticulum is found, which has no fibrous band and no attachment of its distal end, and has not been the cause of any trouble, it may be left as it is extremely improbable that it will have any harmful effect. If, however, there is a fibrous band, especially if this is attached, it should be removed.

In cases where the diverticulum has been the cause of any trouble calling for an abdominal operation it should always be removed. Generally speaking, as in the case which we have gone into in some detail, at the time of the emergency operation it will be best to relieve the acute condition and leave the removal of the diverticulum to a subsequent operation. If, however, the intestine or the diverticulum itself is gangrenous, the gangrenous portion will have to be excised and the diverticulum can be dealt with at the same time.

Another group of cases is that where the diverticulum gives rise to a fistula, cyst, or polypoid tumour at the umbilicus. These cases are often seen in infants and are best treated locally, but it is certainly best that in such a case the diverticulum should be removed when the child is older in order to get rid of a structure which possibly or even probably will at last be the cause of an acute abdominal emergency.

Publications Received.

The Antiseptic, Architectural Association Journal, Archives of Medical Hydrology, St. Bartholomew's Hospital Journal, Burma Medical Times, The Caduceus, The Dragon, The Isis, London Hospital Gazette, Middlesex Hospital Journal, St. Mary's Hospital Gazette, Manchester University Medical School Gazette, Medical Journal of South Africa, Nursing Times, Northampton Gazette, The Northerners, New York State Journal of Medicine, New Zealand Medical Journal, Philippine Journal of Science, The Prescriber, The S.W.P.I. Magazine, Sidney University Medical Journal, University College Hospital Magazine and Dental Notes.

Guy's Nineties Club.

(Union of "Goblins" and "Contemporaries").

The Annual Meeting and Dinner took place at Oddenino's on Wednesday, May 3rd. The following members were present:—Percy F. Henry (President); A. C. H. Gray, A. Miller, P. W. L. Camps, D. G. Greenfield, W. J. Lindsay, E. J. F. Hardenberg, G. B. Pearson, W. E. Hills, E. F. Clowes, J. Lewin Payne, Sir Kenneth Goadby, E. B. Dowsett, Sir J. Atkin, E. W. Goble, H. M. Parrott, A. Kinsey Morgan, A. H. Spicer.

Letters and messages of regret for non-attendance were received from the following:—A. E. Porter, T. Brice Poole, M. Way, F. O. Stoker, M. Thornely, H. L. Eason, N. I. Spriggs, R. H. J. Swan, G. Simpson, L. McGavin, R. S. Roper, P. N. Blake Odgers, F. E. Fremantle, H. J. Starling, P. Turner.

The next Dinner will be held on the first Wednesday in May, 1923.

Papers by Guy's Men.

T. Izod Bennett, M.D. On Certain Conditions Associated with Deficient Secretion in the Upper Alimentary Tract.—*Lancet*, June 10th, 1922.

J. V. C. Braithwaite, M.B. Evidence of Pancreatic Disorders in Rickets.—*B.M.J.*, May 6th, 1922.

H. C. Cameron, M.D. The Suction Difficulties of Young Infants.—*Lancet*, May 13th, 1922.

R. Davies-Colley, C.M.G., M.Ch. Postural Subsartorial Bursitis.—*Lancet*, June 3rd, 1922.

A. F. Hurst, M.D. An address on the Sins and Sorrows of the Colon.—*B.M.J.*, June 17th, 1922.

——. Urea Concentration Test "Cardioplasm" or "Achalasia of the Cardia."—*Lancet*, May 27th, 1922.

J. D. Malcolm, F.R.C.S.E. Surgical Shock.—*Med. Press and Circ.*, May 17th, 1922.

N. Mutch, M.A., M.D., F.R.C.P. Cardio-Vascular Disorders Produced by Disease in the Digestive Tract.—*N.Y. Med. Journ.*, February 15th, 1922.

J. A. Ryle, M.D. Differential Diagnosis between Cholelithiasis and Ulcus Duodeni.—*Lancet*, June 10th, 1922.

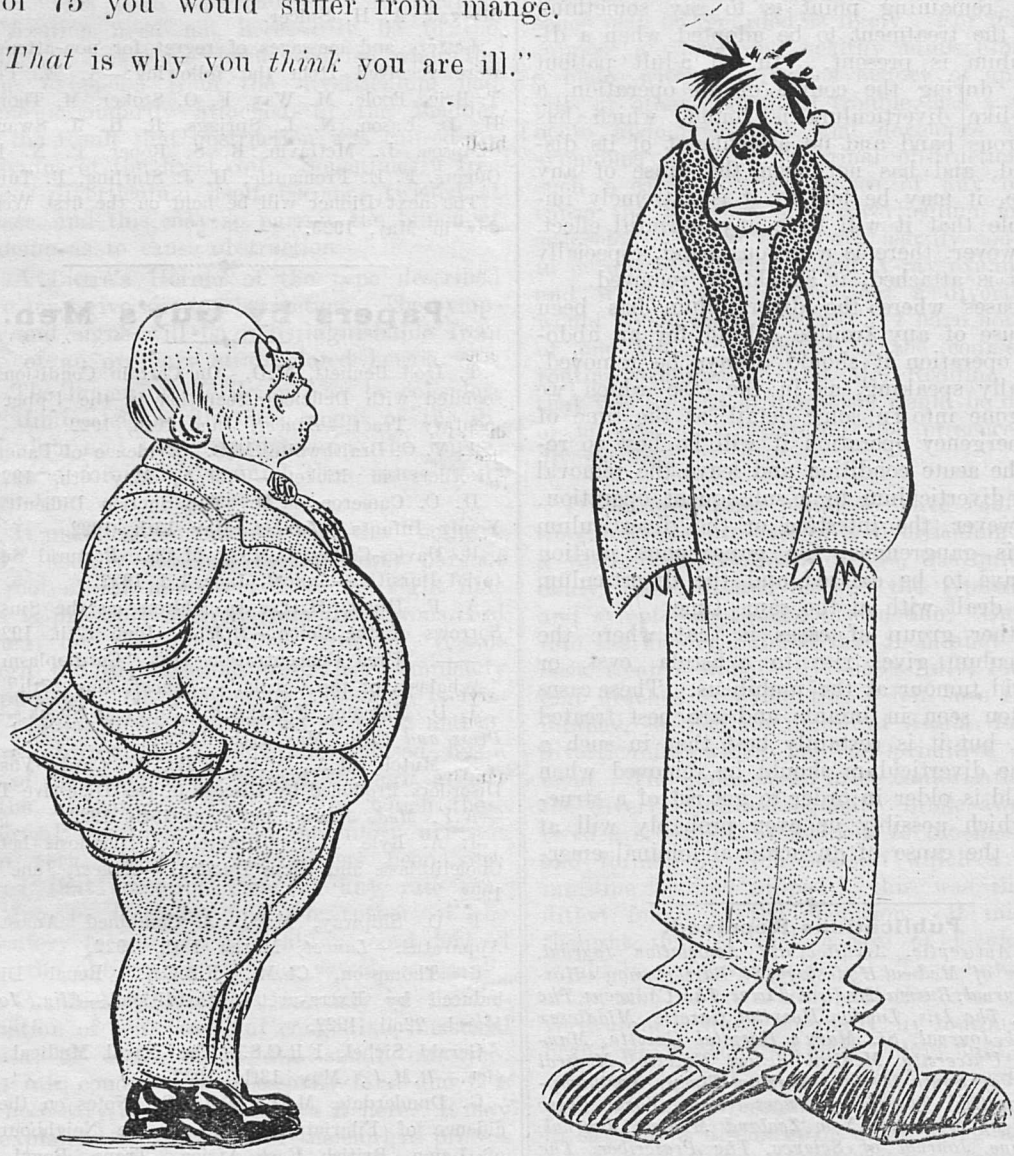
F. O. Shipway, M.D. A Combined Anæsthetic Apparatus.—*Lancet*, March 11th, 1922.

R. Thompson, Ch.M., F.R.C.S. Renal Disease induced by Extra-uretric Conditions.—*Clin. Journ.*, March 22nd, 1922.

Gerald Sichel, F.R.C.S. The Naval Medical Service.—*B.M.J.*, May 13th, 1922.

G. Dunderdale, M.D., M.R.C.S. Notes on the Incidence of Filarial Infection in the Neighbourhood of Lamu, British East Africa.—Trans. Royal Soc. Tropical Med. and Hygiene, Nov. and Dec., Vol. xv., Nos. 5 and 6, pp. 190—197.

"Oh, yes—before you were born, your mother dreamed that at the age of 75 you would suffer from mange. *That* is why you *think* you are ill."



THE DIAGNOSTICIAN.

Reviews.

The Practitioner's Manual of Gynæcology. By A. C. Magian, M.D. (Messrs. William Heineman, Ltd.) Price 21s. net.

There are, at the present time, so many excellent works on Gynæcology that a writer who presents the medical public with yet another book on this subject should have some new teaching to impart or should be gifted with an unusual power of expression. We doubt if Dr. Magian's Manual can be justified on either of these grounds.

In his discursive chapters on the usual gynæcological topics the author relies mainly upon the opinions of the standard British writers and the personal contributions, though they enliven the text, are not such as to carry much conviction. A disciple of the late Prof. Doyen of Paris is expected to have an original outlook, but we find only dogmatic assertion unsupported by reasoned argument; the discriminating reader is left to separate the wheat from the chaff.

In the large section of the book devoted to surgical operations preliminary and post-operative treatment is discussed reasonably well, but the descriptions of surgical technique are unnecessarily extended in their scope. At least one hundred pictures, borrowed from the catalogues of surgical instrument manufacturers, are reproduced. Is the reader to assume that the author includes in his armamentarium six different varieties of uterine dilators? Presumably the picture of a pair of autopsy bowel scissors has crept in by mistake.

The chapter on venereal diseases is instructive and helpful as it is evidently based upon sound practical experience.

We found this book laborious reading not so much on account of the absence of literary style as from the too frequent interruptions of the sense of the text by interpolated information. If it is desirable to state the nationality and the date of birth and death of every authority quoted, these details would be more suitably reserved for an appendix and should not be given in brackets after his name; the same remark applies to the etymological derivation of the Latin and Greek terms in common use.

This work hardly deserves the flattering encomiums bestowed upon it by the publishers in their advertising circulars.

Influenza. Essays by several Authors, edited by F. G. Crookshank, M.D., F.R.C.P. (Messrs. William Heinemann, Ltd. 1922.) Price 30s. net.

It is indeed remarkable that although the diagnosis of influenza for many years had been the refuge of the practitioner when faced with any pyrexial disease that he could not fit into any other category, yet when the great influenza pandemic of the last few years started, no one suspected its true nature. Dr. Adophe Abrahams, who contributes the article on Clinical and Therapeutic Considerations in this volume freely admits that both he and those who worked with him were misled as to the nature of the disease which they described as "purulent bronchitis," in 1917.

The book give a comprehensive account of influenza, both from the clinical and from the historical and epidemiological points of view. The amount of literature that has accumulated on the subject, especially during the past five years, is enormous. Sufficient evidence of this is the fact that in the present volume over thirty pages are devoted to a bibliography of the literature.

The chapter by the Editor on the History of Epidemic Encephalo-myelitis in relation to Influenza is of special interest. He attempts to trace the prevalence of encephalo-myelitis in conjunction with influenzal epidemics, back even to the time of Hippocrates. He regards not only the disease we now know as encephalitis lethargica, but also acute anterior polio-myelitis and even cerebro-spinal meningitis as connected with pandemic influenza. The outbreaks of the polio-myelitis in the United States, in 1916, and of cerebro-spinal fever in England and elsewhere during the war are adduced as evidence for this view.

Some 100 pages of the book are filled with a consideration of the bacteriology of influenza. Dr. Robert Donaldson, author of this section, comes definitely to the conclusion that Pfeiffer's bacillus is not the causal organism, nor does he believe in a filter-passing virus. In fact, according to his view, it is improbable that any single specific and unvarying virus common to all cases of influenza really exists.

In view of the length of the book and the exhaustive way in which the disease is treated, it is hardly to be expected that many will be found who will read it from cover to cover. On the other hand as a work of reference and a compendium of information on the subject of influenza it will hold an unchallenged position.

Blood Transfusion. By G. L. Keynes, F.R.C.S. (Messrs. Henry Frowde and Hodder and Stoughton.) Price 8s. 6d. net.

The enthusiasm evoked by the use of blood transfusion in the war has naturally extended its influence over medical practice during subsequent years. The failures, or even disasters, which in certain cases have undoubtedly followed its employment have sti-

mulated a searching enquiry into the true nature of the physiological processes which take place in the recipient's organism.

The concise manner in which these are set forth forms the most notable feature of this work, which is characterised throughout by an abundance of useful information relating to every aspect of blood transfusion.

The author explains the unpleasant results which frequently arise from transfusing a case of pernicious anæmia with a theoretically compatible blood, by the fact that an extension in agglutinative properties occurs in certain diseases. He emphasises, therefore, the great importance of actually testing the blood of the recipient against that of the donor before proceeding to transfusion.

The difficulty in explaining why Group IV. can be used as a universal donor, although the serum agglutinates other groups *in vitro*, is explained on the assumption that its agglutinins are absorbed by the excess of the recipent's cells; the older view that it is due to a diluent effect must be rejected because agglutination occurs *in vitro* in 1 in 150, whereas the dilution in the body is rarely less than 1 in 7.

The author records several interesting experiments with reference to the presence of definable blood groups in the new born child. He found that although it is unusual for a group reaction to be present in the serum before one year of age, yet marked agglutinophilic properties are often present in the *corpuscles* at birth. Consequently, when transfusing blood from mother to child, serious symptoms may arise if this factor has not been guarded against.

Perhaps the most interesting section of the book is that relating to the inheritance of blood groups which are definitely transmitted on the Mendelian plan. The practical application of this fact is demonstrated by Learmouth's case in which a Group I. child was supposedly born of Group IV. parents; the only explanation of this occurrence being that the putative father was not the real male parent.

The actual details of transfusion technique are fully dealt with, and a simple, portable apparatus described. Insufficient attention has, however, been given to the Stansfield-Ryffel appliance.

Mention is made of Robertson's somewhat heroic "complete replacement method" for cases of toxæmia and septicæmia in children, in which the infant's blood is withdrawn from the superior longitudinal sinus and replaced by transfusion into the saphenous vein. This evidently appeals so strongly to the writer that he closes with the remark that some *vieillard* might in this way attempt rejuvenation!

A Clinical Treatise on Diabetes Mellitus. By Marcel Labbé, M.D., translated, revised and edited by Charles Greene Camston, M.D. (Messrs. William Heinemann, Ltd.) Price 18s.

The modern treatment of diabetes depends on two principles, absence or diminution of carbohydrates and under-nutrition. It is true that one sometimes meets with patients who do not do well, if these methods are used. It is indeed possible that the liver is the organ chiefly at fault in such cases. It still remains true, however, that treatment founded on these principles is the best that can be employed in the majority of cases in the present state of our knowledge. It is a vast improvement on methods used before, and one would expect that in a modern treatise on diabetes this treatment would occupy a central position. Such can hardly be said to be the case in this book. It is true that there is a chapter on fast cures in diabetes, but the principle of under-nutrition is not enunciated, except for fat subjects, and the reader will look in vain for any precise directions how to treat a patient, such as he would find in, say, Joslin's Treatment of Diabetes.

The book consists of a series of lectures delivered at different times during the last 14 years, and such a plan precludes the possibility of any unity in the treatment of the subject, leads to overlapping, and sometimes to inconsistences. For instance, in one place a description of the blood in acidosis is given and the β-oxybutyric acid is said to "force carbonic acid out of the plasma," although Beddard, Pembrey and Spriggs showed many years ago that this conception was wrong. It is, in fact, the respiratory centre that causes this diminution of CO_2, by increasing the pulmonary ventilation. The editor adds a chapter on the ammonia index, *i.e.*, the ratio of ammonia nitrogen to total nitrogen in acidosis. However, when the actual diagnosis of coma is considered in another chapter, no use at all is made of these facts, although they are really of very great importance in this connection.

We cannot recommend the book as a guide for practitioners, although students especially interested in diabetes will find many striking clinical facts recorded, and will get a good idea of views on diabetes that have been held in France and Germany during the last ten years or so. We notice that no mention is made of the respiratory exchange, or of Rothera's test, and there are a fair number of mistakes in different parts of the book.

The translator certainly cannot be congratulated on his part of the work. The following is a list of "new" English words that he has coined: acidosic, larvate, declivous, ictus, anticetogenous, significative, commemoratives, officinal, comatous, brightic, hydropigenous, gavage, preconized, comatigenous, pathogenical. We certainly hope that these words will not come into general use. It is a surprise that the publishers allowed them to pass. E. P. P.

Permeating Mastoid Meningitis. By J. B. Pike, M.R.C.S., L.R.C.P. (Messrs. John Wright & Sons, Ltd.) Price 1s. net.

In this brochure, Mr. Pike sets out to focus attention on a type of mastoiditis, which is not common, but of which he has seen many cases in the course of his practice as a hospital surgeon. In this type (as we understand it) infection enters the mastoid antrum via the aditus and without setting up abscess formation in the antrum tracks upward "permeating the mastoid bone in the direction of the periosteum of the cerebral surface, threatening meningitis and brain abscess." Such a clinical entity defies early diagnosis. There is no otorrhœa nor is there any bulging of the drum, for there is not a definite purulent otitis media to cause either of these symptoms. There is no tenderness nor œdema over the mastoid process, for the cells of this process are not invaded. All that we have to go upon before symptoms of cerebral irritation arise is a vague temporal pain which is easily overlooked.

Mr. Pike wishes us to bear always in mind that such a pain must not be lightly overlooked, but must be considered with a full comprehension of future possible disastrous sequelæ. The treatment advocated by Mr. Pike is free exploration of the antrum, with special regard to the invasion towards the meninges. His technique is similar to that usually used for such an operation. He pours into the antrum during the operation some hydrogen peroxide, which he says will reveal the presence of pus. It seems probable to us that the fallacy of effervescence due to the presence of blood must nullify the value of this test.

We appreciate the importance of being prepared for permeating mastoid meningitis, but we cannot believe that operation is imperative in many of the doubtful cases in which Mr. Pike would seem to advocate it.

Notes on Dental Metallurgy. By W. Bruce Hepburn, L.D.S.(Gasglow). Third Edition. (Messrs. Baillière, Tindall and Cox.) Price 7s. 6d. net.

This book forms a good introduction to the subject of Dental Metallurgy and should be recommended to dental students. The most attractive feature is that the author so frequently illustrates his points from practical experience and also quotes original investigations, which serve to remind the student that there is a great deal to be learnt about the subject beyond what is contained in the text. The report on metals used in the mouth is well worth careful study and the chapter on the constitution of alloys is a very good introduction to the subject.

There are a few criticisms of perhaps minor importance which might be offered. It is somewhat unfortunate that errors which occurred in the second edition have not been corrected in the present one. For example, the formulæ of mercurous chloride, on page 22, and sodium chloride, on page 79, are wrongly given, and the definitions of distillation and sublimation, with the examples, on pages 12 and 13 are a little confused. On the whole, the metallurgical treatment of the metals is very well described, and the author, in certain cases, has made the description more valuable by using chemical equations to describe the reactions involved. It would increase the value of the book if this were done more generally.

The Story of Southwark Cathedral. In fourteen chapters with eight illustrations. By the Rev. T. P. Stevens, Succentor and Sacrist. (Messrs. Sampson, Low, Marston and Co.) Price 2s.

This modest little work is dedicated to "the man on London Bridge" and is exactly calculated to meet the requirements of that hurrying person. For Mr. Stevens has succeeded in writing a guide book which is thoroughly human, avoiding the snare of an over-abundance of architectural and ecclesiastical detail, and at the same time attractively marshalling the main facts of general historical interest and pointing out the chief features of a fine old Church. The Cathedral is rich in literary associations as the memorials to Gower, Shakespeare, Massinger, Fletcher, Beaumont and others testify. We who number Keats among our past students find here another link between literature and medicine in the Goldsmith window with its reminder that before migrating to the Temple Oliver Goldsmith practised as a doctor on Bankside. Can some antiquarian tell us if he came into partnership—or collision—at this time (roughly 1760—70) with the Staff at Guy's? Another doctor—actually buried in the Cathedral—is Lyonell Lockier who, in Charles II.'s reign claimed to cure every disease with a particular pill, the valuable properties of which he extracted from the rays of the sun. His prospectus was so attractive that one wonders what his relations were with the Seventeenth Century St. Thomas'. He claimed to cure "feavers, leprocies, dropsie, frensie, palsie, rheums," and "to make old age comly and the countenance of all to be chicerful and sanguin." Really he almost deserved a Cathedral burial for that sentence alone!

The story of the fight between ourselves and St. Thomas' in 1836 is faithfully told on p. 89, in a chapter on St. Thomas'. Winchester Palace, of which traces are still to be seen on Bankside and in the "Clink," has a chapter to itself.

The illustrations are excellent, and we can promise any Guy's Nurse or Student who will spend an hour or two with this little book as guide, an interesting and delightful tour of a too-little known Cathedral.

Like the "man on London Bridge" we are continually passing Southwark Cathedral. Mr. Stevens has removed any excuse we may have had for not forming a closer acquaintance with its history and its architecture.

May we venture a hope that Mr. Stevens will give us another book? Clearly he is a mine of information and, what is more, knows how to assemble and present it. There is a great deal of historical interest in Southwark and we should like to hear about it.

Archives of Occupational Therapy. Edited by W. R. Dunton, Junr., M.D. Price $5.50.

These archives form the official organ of the American Occupational Therapy Association and consist of a collection of articles dealing with suitable means of employment of sufferers from various diseases.

The aim of the science is not only to turn the patient's thoughts from his malady, but also so to direct his activities as to render them therapeutic agents of no mean value.

In an interesting article on recreational therapy for heart disease, F. Brush observes that, "Cardiacs need particularly correction of neuroses and faulty mental attitudes, upbuilding of general, physical, and heart muscle strength, through short period activities, and the inculcation of ways of life that will carry on into the main pursuits—which are happiness and service." He believes that such activities are safe on the grounds that cardiacs will instinctively grade themselves into suitable restorative exercises.

The inclusion of the "Report of the Round Table of Bookbinding" in the Archives scarcely adds to their general interest, for it consists of numerous technical details (such as putting a drop of carbolic acid in the paste used in order to keep the worms out!), which throw no light whatever on the fundamental principles involved.

Rickets. By J. Lawson Dick, M.D.(Ed.), F.R.C.S. Eng. (Messrs. William Heinemann). First Edition. Price 25s.

In his book entitled "Rickets," Dr. J. Lawson Dick examines with great minuteness the geographical distribution of Rickets, and the dietary of the infant population in many countries. As a result of this examination he regards it as certain that the dietetic factor has no primary ætiological significance. He finds the disease confined to a strip running across Europe and North America, between the latitudes 40° and 60° North, an area characterised by wet and damp, by long cold winters and scanty sunshine. In lands outside this area, however meagre or monotonous the diet, in rice eating India or China, Rickets is almost unknown.

In an interesting part of the book he reviews the changing economic conditions under which the people of these Islands have lived. If his sources of information are not as a rule very recondite, he shows clearly enough, by quotations from Evelyn's Diary, and from "The Memoirs of the Verney Family," that infant mortality in the 17th Century had reached prodigious heights, even among those who exercised the greatest care, or perhaps, as Evelyn himself shrewdly suggests, because an excess of anxiety produced the very results it meant to avoid. Evelyn's own rachitic 5 year old son—a "prodigy of wit and learning," and a classical scholar in his father's opinion—was "suffocated by the women and maids that attended him, and covered him too hot with blankets as he lay in a cradle, near an excessive hot fire in a close room." As for Jack Verney, in the year 1647, three years before Glissons book was published, "his legges are most miserable, crooked as ever I saw any child's, and yett thank God he goes very strongly,—A very fine child all but his legges, and truly I think he would be much finer if we had him in ordering, for they lett him eate anything he hath a mind toe and he keeps a very ill diett."

Dr. Dick's book makes interesting reading, even if it does not go far to settle this much disputed question, the ætiology of rickets.

Cricket.

GUY'S v. HAMPSTEAD.

Played at Hampstead on Wednesday, 24th May.

Hampstead batted first; they had made 60, and looked like making many more, when Saunders was run out. 30 runs later Van Schalkwijk took two wickets together, and Shearar caught Crump at forward square leg. Boney played well, hitting hard all round the wicket, and he was well supported by Keeson towards the end. Their declaration left us with just over two hours to bat. Things did not go at all well for us until Shaw and Wooldridge got together; they both scored quickly. Wooldridge was stumped in trying to hit a 6. Shearar played quite well, making some lovely cuts. Bernstein went in to hit, and he knocked up his 38 in a very short time. I believe that had we had time we could have won, for Bernstein seemed quite happy, and Arkles was playing steadily.

Hampstead.

F. R. Monro, b Van Schalkwijk	31
A. G. Saunders, run out	34
T. H. Farmiloe, b Van Schalkwijk	14
D. J. Crump, c Shearar b Arkles...	26
G. G Dumbleton, c & b Arkles...	13
A. R. Boney, not out	70

C. Nicholson, b Van Schalkwijk...	17
D. C. Keeson, not out	26
Extras	20
Total	251

Did not bat: J. Mackie, H. M. Gray, E. H. Hewetson.

Bowling:—Van Schalkwijk, 3 for 59; Arkles, 2 for 52; Shaw, 0 for 14; Wooldridge, 0 for 66; Williams, 0 for 22; Bernstein, 0 for 2; Ensor, 0 for 16.

Guy's.

A. G. Ensor, c Keeson b Saunders	13
J. C. Hewetson, b Mackie...	1
V. R. Estment, b Saunders	8
L. S. Williams, b Dumbleton	9
T. Wooldridge, st Boney b Gray...	43
G. D. Shaw, b Saunders	45
J. G. Van Schalkwijk, c Gray b Dumbleton ...	1
G. L. Shearar, b Mackie	24
H. L. Bernstein, not out	38
C. Arkles, not out	7
Extras	18
Total (for 8 wickets)...	207

Did not bat: J. D. S. Thomas.

GUY'S v. THREE COUNTIES ASYLUM.

Played at Three Counties on Saturday, 27th May.

We always look forward to this match, for Dr. Hunter takes such great care of us, we get a good sporting game, and if at any time the cricket does not keep our attention, the antics of some of the residents afford us ample amusement.

Wooldridge won the toss again and Shaw and Ensor started for us. Buckley was bowling fairly fast and making them swing away. Shaw did not seem to like it at all and soon edged one to first slip. After Ensor had cut his own throat by calling for an impossible run, Helder and Arkles stayed together for some time. Arkles batted very well, sending all short ones for four in the most approved style. He and Helder put on 60 for the third wicket. Helder took a long time to settle down, but he played steadily throughout and gave no chances. He hit one terrifically hard to mid-on; Hunter put up one hand, stopped it, and caught it as it dropped—a lovely catch. Isaacs did not even attempt to play the ball—he only got one—and Kitchen did not look at all safe. Biddle hit some very hard and nearly hit several others.

We got them out fairly easily, although Goddard played very well and had several partnerships, which, although short, seemed at the time as if they would cause us trouble. Most of us should have gone out with baskets, for what with dropped catches and poor ground fielding we put up a very bad show. Biddle did not bowl extraordinarily well, but he was quite puzzling enough for their tail.

Having won the game an hour and a half before it was necessary to stop, we made a little effort to brighten cricket. We had three quarters of an hour each in which to bat. We managed to get 119, while they got 105.

Guy's.

G. D. Shaw, c Goddard b Buckley	9
A. G. Ensor, run out	7
L. B. Helder, c Hunter b Buckley	73
A. C. Arkles, c Albon b Sanders	34
T. Wooldridge, b Albon	15
J. Van Schalkwijk, b Buckley	11
A. Isaacs, b Buckley	0
F. J. Biddle, b Buckley	19
H. L. Bernstein, b Albon	5
A. J. Kitchen, not out	3
E. J. Crisp, b Buckley	7
Extras	12
Total	195

Three Counties

P. D. Hunter, c Van Schalkwijk b Biddle ...	3
H. B. Goddard, st Crisp b Biddle	56
T. W. Sanders, b Wooldridge	3
E. C. Clouston, b Wooldridge	1
B. L. Prior, run out	2
E. G. Albon, b Biddle	15
—. Buckley, not out	14
W. Robinson, b Biddle	11
P. Whaley, c Kitchen b Biddle	2
H. Searle, c Kitchen b Biddle	4
F. Fawell, b Biddle...	12
Extras	2
Total	125

Bowling:—Van Schalkwijk, 0 for 36; Biddle, 7 for 66; Wooldridge, 2 for 18; Shaw, 0 for 3.

GUY'S v. L. C. W. & P. BANK.

Played at Norbury on Saturday, June 3rd.

Guy's.

G. D. Shaw, st Piercy b Harker...	15
A. C. Arkles, c Kirk b Harker	1
L. B. Helder, not out	17
L. S. Williams, c Kirk b Norman	26
T. Wooldridge, c Littlewort b Lear	38
J. Van Schalkwijk, b Kirk	7
G. L. Shearar, b Kirk	2
Extras	4
Total (for 6 wickets)...	140

Did not bat: F. J. Biddle, A. Isaacs, J. C. Hewetson, G. W. Rees.

L. C. W. & P. Bank.

Norman, b Van Schalkwijk	11
Lear, b Wooldridge	13
Kirk, c Helder b Van Schalkwijk	47
Littlewort, b Biddle	5
Heron, b Wooldridge	9
Bradley, b Van Schalkwijk	0
Carter, c Wooldridge b Van Schalkwijk... ...	1
Horne, b Biddle	0
Piercey, b Biddle	4
Musson, not out	4
Harker, b Van Schalkwijk...	5
Extras	16
Total	115

Bowling.—Van Schalkwijk, 5 for 38; Shaw, 0 for 23; Wooldridge, 2 for 17; Biddle, 3 for 21.

Guy's Hospital Rifle Club.‡

The first and second shoots for the Armitage Cup were fired off at Bisley on 7th and 14th inst. respectively. At the first shoot Bart.'s obtained a strong lead of 62 points owing to the fact that Guy's were using a new cordite ammunition for which their rifles were not sighted. This was entirely the fault of the Secretary who obtained a better and more consistent ammunition than that usually issued, but omitted to find the degree of elevation comparative with the usual issue, an unpardonable oversight in one whose knowledge of rifle mastership should be proof against elementary errors of this description. At the second shoot the mistake of the preceding week was adjusted and 16 points disappeared from Bart.'s lead. With careful shooting the Cup should stay with Guy's, but every ounce of energy and rangecraft must be employed. Bart.'s,our only serious competitor, have an unusually strong team this year.

Scores—

First Shoot.—Bart.'s 495, London 462, Guy's 432, St. Thomas's 365.

Second Shoot.—Guy's 510, Bart.'s 494, London 467, St. Thomas's 348.

Position to Date.—Bart.'s 1st, 989; Guy's 2nd, 942; London 929; St. Thomas's 713.

Spoons were won during the two shoots by Bingay, 600 yds. and 500 yds.; Taylor, 200 yds.; Foy, 500 yds.; Hallpike, 200 yds.; Hart, 600 yds.

Guy's Team.—Taylor, Bingay, †Hopson-Jones, *Hart, Hallpike, Lloyd, Foy.

†First shoot only. *Second shoot only.

‡See p. 280.

The Inter-Hospital Boat Race, 1922

Considering the unusual amount of sunshine we have enjoyed already this summer it was unfortunate that the day of the Race for the United Hospitals' Challenge Cups should have been so cold and windy. Of all sports rowing is the one which is least affected by weather conditions. Wet or fine, warm or cold, calm or stormy, crews will go out and, if need be, crews will race. But the comfort of competitors and spectators is alike enhanced by fine conditions.

Wednesday, June 14th, was a thoroughly bad one from all points of view. A cold wind and threatened rain kept all but the most enthusiastic spectators away. A stiff head breeze and rough water made it problematical whether the crews would cover the course without sinking.

For the first time since the war the Junior Cup was up for competition. Bart.'s and Guy's, as in the Senior event, were the only crews competing, and the race was rowed in clinker built boats with coxswains. The crews got away from their stake boats at 4.40 p.m., followed by the Umpire's launch and a steamer load of men from the Hospitals. Bart.'s, rowing a slightly faster stroke, quickly took a lead which they increased to about three quarters of a length by the boat houses. Here Guy's spurted and drew practically level, and a fine finish was promised. Unfortunately Bart.'s, who had not been coping with the rough water quite so cleverly as their opponents, were delayed by a "crab" and quickly dropped two lengths, at the same time getting out of their course. After this the result was never in doubt, Guy's passing the mile post $3\frac{1}{2}$ lengths in front.

The crew had been very little together before the race and, while making no pretence to anything very great in the way of oarsmanship, rowed quite soundly and always appeared the steadier crew. They looked like winners before the accident to their rivals.

The Senior Race was rowed as usual in coxwainless boats. Miller won the toss and chose the Middlesex station. The previous race delayed the start to some extent and the start was not made until 5.20. Guy's got away well and, rowing the slower stroke, were soon leading. The steering on both sides was a trifle erratic and both crews were warned for trespassing on their opponents' water. Partly, no doubt, from anxiety to avoid a foul, Chambers steered too close in shore and got into the dead water under the wall, leaving Bart.'s the full benefit of the tide. At Craven Point he was far too close in and only a few yards separated the bow side blades from the shore. Notwithstandnig this, Guy's easily maintained the lead, and after rounding the point Chambers steered well, and by the time the crews passed Har-

rod's, Guy's were leading by two lengths. Neither crew was comfortable in the bad water, but the Bart.'s men displayed inferior watermanship and seemed more troubled by it than the Guy's crew, who rowed a slower stroke all over. Bart.'s made a vigorous effort after Harrod's, and closed the gap a little. Here Chambers came across and took their water, rather unnecessarily, but Bart.'s replied by changing places. The final effort of Bart.'s seemed too much for them, and the Guy's crew passed beneath Hamersmith Bridge fairly easy winners by $3\frac{1}{2}$ lengths.

There can be no doubt that the better crew won. Admirably stroked by Miller, they were well together and had no difficulty in maintaining and increasing their lead, though the rate of striking never exceeded thirty to the minute. The Bart.'s men worked tremendously hard, but were never really together and could not sit their boat, chiefly from attempting too fast a stroke. Both crews lost pace by indifferent steering, but steering a coxswainless boat, always a difficult task, was rendered doubly difficult by the bad conditions.

Mr. Souttar, of the London Hospital, President of the United Hospitals' Rowing Club, kindly and very ably officiated as Umpire, and Mr. F. C. Cleaver, of the London Rowing Club, acted as Distance Judge.

Names and Weights—

First Crew.

Bow (steers) R. S. Chambers, 10st. 7 lbs.
2. G. C. Hughes, 11st. 2 lbs.
3. K. O. Parsons, 13st. 0 lbs.
Stroke F. C. Miller, 12st. 7 lbs.

Second Crew.

Bow C. H. C. Toussaint, 10st. 8 lbs.
2. A. Tom, 11st. 1 lb.
3. E. T. Clifton, 10st. 4 lbs.
Stroke A. S. Gough, 9st. 5 lbs.
Cox D. Vaughan.

Tennis.

A very successful Mixed Doubles Tournament was held at Honor Oak Park on Whit Monday, June 5th, in aid of St. Dunstan's Lawn Tennis Fund, which profited to the extent of £6.

An entry of thirty-two couples was received, which, considering that this was the first time a mixed doubles tournament had been held at Honor Oak Park, and that it was the Whitsun weekend, was highly satisfactory.

The four sections were very evenly contested, the winners being:—

Sister Burton and Mr. Laver.
Miss Bentley and Mr. Sharpley.
Miss B. Cole and Mr. Suzman.
Sister Johnson and Mr. Cann.

The play in the semi-final and final was very keen, Miss Bentley and Mr. Sharpley winning the final after a hard fought match against Miss B. Cole and Mr. Suzman.

The Committee wishes to thank Miss Scott for presenting the medals given by St. Dunstan's; Sister Dixon, Sister Andrews and Mr. Watson for the excellence of the tea arrangements, and the Nursing Staff for the very generous manner in which they responded to the request for cakes, which were sold for the Fund. Although signals of distress were sent to the Committee to refrain from eating too much, there was plenty left over.

The Committee hope to arrange another tournament before the end of the season, and hope that there will be more entries from the Staff.

Inter-Hospital Sports.

The Annual Inter-Hospital Sports were held at Queen's Club on Saturday, June 10th. The meeting was arranged by the King Edward's Hospital Fund and was very widely advertised in the hope of getting a big crowd. But this hope did not materialise.

A very interesting afternoon of keenly contested events ended in a handsome win for us. We got back the Shield, which we lost to King's last year, with 78 points. King's were next best with 52, and Bart.'s were third with 46 points. There is no doubt that Bart.'s would have made things very warm for us, had they not been so unfortunate as to be deprived of the services of H. B. Stallard, who met with an accident the day before. However, we should have just won, even if Stallard had been running.

The great feature of the afternoon was the extraordinarily fine performance of C. L. Steyn. He got first in four events, the 100 yards, 220 yards, 440 yards and the long jump, and after all this he ran a 220 yards in the relay race in which he set up a very fine lead. Perhaps the most brilliant of his many successes was the quarter-mile, in which he beat J. C. Ainsworth-Davis in the very fine time of 50 4-5 secs. It was a very fine run to watch and was a good example of what an advantage can be gained by using one's brains.

All the men who gained points for the Hospital put up very good performances, as also did G. K. Lacey. In both his events he was up against Steyn

and Ainsworth-Davis and so of course was never expected to get second place. But he ran extremely well, especially in the 220 yards.

The following gained points for the Hospital:—

C. L. Steyn, 1st in 100 yards, 220 yards, 440 yards, Long Jump—40 points.

P. K. Albertijn, 1st in Putting the Shot and Hurdles—20 points.

L. G. Housden, 2nd in 3 miles—6 points.

A. S. Gough, 2nd in ½ mile—6 points.

F. G. Hutchinson, 2nd in Putting the Shot—6 points.

Pass List.

Royal College of Surgeons of England.

F.R.C.S.

FINAL EXAMINATION. JUNE, 1922.

J. F. Carter Braine, M.B. C. H. Medlock, M.B.
J. Gaymer Jones, M.B. J. Victory.
G. Massie, M.B.

Mr. W. H. Grace has been awarded the Conjoint Diploma in Tropical Medicine and Hygiene.

ELECTION OF EXAMINERS—ANATOMY.

Mr. A. R. Thompson, Ch.M., F.R.C.S., has been re-elected an examiner for the ensuing year for the First F.R.C.S.

Royal College of Physicians.

Dr. H. W. Barber, M.B., B.C.(Cantab), was elected a Fellow of the Royal College of Physicians on May 11th, 1922.

Appointments.

Civil.

A. B. Danby, F.R.C.S.E., has been appointed Hon. Assistant Obstetric Officer, Birmingham General Hospital.

J. V. C. Braithwaite, M.B., B.S., M.R.C.P., has been appointed Hon. Assistant Physician, Leicester Royal Infirmary.

Miss F. A. Sheldon has been appointed Registrar to the College of Nursing, Ltd., 7, Henrietta Street, Cavendish Square, W.1.

Royal Navy (Dental).

Surg. Lieut.-Commander R. R. Adams (D), to *Benbow*.

Temp. Surg. Lieut. (D) E. C. Bevis, to *Ganges* for Boys' Training Establishment, Shotley.

Temp. Surg. Lieut. (D) D. C. Eglington, M.C., to *Pembroke*, additional for R.N. Barracks, Chatham.

RIFLE CLUB.

The Annual Prize Meeting will take place at Bisley on Wednesday, 28th inst., in conjunction with the Annual Meeting of the United Hospitals Rifle Club.

EVENTS AND PRIZES.

200 Yards Deliberate.—Cup and 3 prizes + two Guy's prizes and Spoon.

500 Yards Deliberate.—Cup and 3 prizes + two Guy's prizes and Spoon.

600 Yards Deliberate.—Cup and 3 prizes + two Guy's prizes and Spoon.

1,000 Yards Deliberate.—Cup and 3 prizes + two Guy's prizes and Spoon.

Snapshooting and Rapid Firing.—1st and 2nd prizes + two Guy's prizes and Spoon.

Grand Aggregate.—Rifle, value £10 10s., and second prize.

Newton-Pitt Cup and second prize (for Guy's only).

No entrance fees. Free ammunition, rifles and targets.

Specially reduced fares at 3s. return. Vouchers from W. H. Foy or College Lodge.

Only condition.—Membership of Clubs' Union.

Range available from 10 a.m. till 6 p.m.

Lunch and tea may be obtained on the range.

Entries should be placed on sheet on Rifle Club Notice Board in Colonnade before Tuesday, 27th, ½ p.m., or given to

W. H. FOY, *Hon. Sec.*

Birth.

COLE.—On May 4th, 1922, at 65, Broomwood Road, Wandsworth Common, S.W.11, to Doris Margaret, the wife of A. Hedley Cole, L.D.S., a daughter.

Marriage.

JAMES—DUMBULL.—On June 2nd, 1922, at St. Bartholomew's Church, Horley, by the Rev. H. T. Lewis, John James to Ada Joan Dumbull, youngest daughter of the late Rev. J. J. Dumbull, Vicar of Copthorne, Surrey.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT has been observed that an army marches upon its stomach, and there can be few who would dare to deny that in the hospital, as in the military life, proper attention to this necessary organ is essential to well-being, while continued neglect leads to tragic results.

It cannot be said that there has ever been a lack of interest in the catering arrangements in the Students' Club. In fact, as is the case in most men's clubs, the claims of the inner man have been urged with insistence, while any unsatisfactory arrangements have led to many complaints, throughout the history of the club.

We are once again faced with a recrudescence of this old, old problem, and after several weeks of negotiations on the part of the College Committee and of the Students' Club Committee, matters have come to a head. Those who were able to attend the meeting held on Thursday, July 6th, are doubtless in full possession of the facts. Briefly, the position is this. The College Committee at present are the arbiters of our fate as regards food. They make the catering arrangements, and it is to them that complaints and suggestions are made.

On May 31st, 1920, the Students' Club Committee acquainted them with the fact that a resolution had been carried to the effect that the catering in the College was unsatisfactory, and that immediate steps should be taken to rectify it.

Since then there have been from time to time meetings and discussions between the College Committee and bodies representative of the students, without any very tangible results.

Now we are faced with the announcement that the Aerated Bread Co., who are the present caterers in the College, have been given notice that the agreement with them is to be terminated. At the same time we hear that arrangements are being made for the Imperial Restaurant to take over the catering in the College.

Nearly everyone who takes his meals in the College finds it difficult to believe that this change will be a change for the good. The Residents are opposed to it to a man.

If the College Committee, hearing of this opposition, were to exclaim, "Well, we have

done our best for you. You wanted a change. Now, after two years, you have got it, and you are still not satisfied," we should regard their exclamation as a most natural one under the circumstances.

But still, let us beg them to remember that it is two and a half years since the need for immediate reform was urged, that no representations were made to the A.B.C. at the time the resolution was passed, and that we do not think the Imperial Restaurant will improve conditions.

The A.B.C. themselves have improved considerably of late; the prices charged by the Imperial Restaurant will be higher, on the whole, than those charged by the A.B.C., while we understand that they will impose certain restrictions not at present in force.

We are strongly of opinion that the wishes of students should be consulted when it is a question of catering in a students' club; at the same time we recognise the difficulties under which the College Committee is working, and appreciate the fact that they have, recently, taken to conferring with representatives of the students.

We realise that it is not easy to persuade catering firms to accept a contract for the College, and that the College Committee are tied to a certain extent by their obligation to provide for the Residents.

Still, we venture to question the wisdom of this leap from the frying-pan into the fire.

We offer our hearty congratulations to Mr. M. E. Shaw, who has been awarded the Treasurer's Gold Medal for Clinical Medicine.

Rugby enthusiasts may have wondered, long before now, why no résumé of the past season has as yet been published. We hasten to assure them that the fault, in this instance, lies with us, and not with the secretary of the Rugby Club. The copy which he sent in to us recently now reposes somewhere on the road between here and Bethlem Asylum. He has been kind enough, however, to furnish us with a fresh résumé, which will appear, together with a photo of the 1st XV., in our next issue.

We hope to publish in our next issue a criticism, by an old Guy's man, of Mr. Arthur Bourchier's production, "The Risk," a play adapted from André Pascal's "Le Caducée." The play, which hits severely at the supposed malpractices of fashionable surgeons in Paris, has raised a storm of protest on the part of surgeons on both sides of the channel, being described as an impossible caricature, a slur on the profession, calculated to do harm to patients, and so on.

The management of the Strand Theatre, possibly intending to convey a delicate hint that they do not imagine all doctors to be villains, have generously suggested that they should give a "Guy's Hospital Night" early this month. They propose to give an ordinary show, and to allow students to collect for the Combined Appeal Fund during the intervals.

As regards the play itself a fuller criticism of it than this can be will be found in the next issue. (We were unfortunately unable to include the criticism in this issue as we had desired.)

The acting undoubtedly leaves nothing to be desired. One or two technical details seem to have gone wrong. We condemn, for instance, the practice of "washing up" in an office (with no one present to open doors), tak-

ing elaborate precautions to don clean gloves, but neglecting to put on a sterile overall.

The play for a time surprised us. We had expected something considerably worse than what we saw. The characters are undoubtedly caricatured, but although we are disposed to question the existence of such conditions in actual life, we found nothing to cavil at. The play was quite amusing and very well acted—and very few plays bear any resemblance to actual life; so why worry?

As the *dénouement* was being worked up, however, a sense of distaste crept over us. Not even the most shameless charlatan could act like this. The conditions under which one of the patients died, while Dr. Revard entertained his lady friends to a matinée in another operating theatre (excision of the pylorus—13 minutes), are too utterly impossible to be accepted.

One of the great faults of the plot is the assumption that men such as Dr. Revard could remain for so long within the profession. The Dr. Godefroys of real life would have exposed them and expelled them long before such a *dénouement* as we have in the play became possible.

In further criticism it may be said that the play can do no good. Mr. Bourchier's acting made an improbable character seem probable to us. If the general public are also made to believe that such surgeons can practice without hindrance from more honourable men, much harm will be done, and their confidence in doctors will be shaken.

Another little thing—do doctors of integrity, such as Godefroy, necessarily possess mean and unattractive consulting rooms?

THE Garden Fête organised by the Ladies' Association met with unqualified success. We hear that as a result, the money in hand is about £1,800 nett. Of this about £1,200 is due, strictly speaking, to the activities of workers at the stalls and side shows, the remainder to collections.

We are glad that the rain did not spoil the many attractions of the fête, and congratulate the Ladies' Association on their great success.

Injury to Epiphysis of the Ulna.

The two following cases show the strain that is thrown on the styloid process of the ulna in such injuries as lead to a Colles' fracture.

Ruth —., aged 13½, fell and endeavoured to save herself with her hand. She presented a typical Colles' fracture with much backward displacement. The fracture was reduced and the skiagrams I. and II. (see inset) were taken a few hours later. The vertical fracture of the ulnar epiphysis is well shown.

Harry —, aged 12½, was keeping goal at football, and struck the ball with the flat of his hand. He experienced pain in the wrist so severe as to cause him to faint. On examination no fracture or displacement could be detected—the most tender spot being on the ulnar side of the wrist joint. He was skiagraphed an hour later and plates III. and IV. (see inset) were taken showing the lesion in the ulnar epiphysis.

G. H. PENNELL.

Edenbridge, Kent.
May, 1922.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

The Annual Distribution of Prizes.

The Awards gained by the Medallists and Prizemen of Guy's Hospital Medical School were presented by Sir William Hale-White, in the Physiological Theatre, on Monday, June 6th, 1922, Lord Goschen (Treasurer) presiding.

After presenting the various Medals and Certificates,

SIR WILLIAM HALE-WHITE said:—My first duty is to congratulate the prize winners and that I do most heartily. I trust their good fortune will continue through their life. Likewise I congratulate the large numbers who, although not fortunate enough to have obtained prizes, have deserved them. Next I most warmly thank the Treasurer for the great honour he has done me in asking me to distribute the prizes to-day. When he wrote to me, he said that one of my duties was to say a few words to you. It is approaching fifty years since I entered here as a student, therefore it naturally seems appropriate that I should speak of your association with Guy's.

All of us who are in this theatre are members of a large, ancient and famous Medical School and from this we derive advantages and duties.

That it is an advantage to belong to a large Medical school is clear, for those who do have a numerous staff of teachers from whom to learn and draw inspiration, each of you has as colleagues many fellow students and it is impossible to over-rate the benefit that flows from associating with others, seeing how they do their work and discussing yours with them. Further, at a large school you see a multitude of patients and therefore numerous varieties of disease. Often have I heard it urged that it is best to go to a small medical school for there it is easier to get appointments. That this is wrong I am sure, for you lose all the above advantages. Who would not sooner be a comparatively humble official in the British Empire rather than President of a small Republic. The proof that I am right lies in the fact that the small schools remain small.

I am not a believer in the superiority of old people, my faith is with the young. Long before other schools had dared we had a rule that teachers should retire from the staff of Guy's at the age of sixty, a most excellent ordinance that has had much to do with the success of the School at which you have that admirable arrangement, an ancient institution carried on by young people. Three years hence it will be two hundred years since Guy's was first opened and shortly after teaching began. Lectures were given at the disagreeable hours of 7.30 a.m. and 8 p.m., but they must have been attractive, for students attended, and from them the School grew. The very fact that the Hospital and School have existed for so long must inspire you to continue well and not to besmirch their traditions. It is a great asset to feel that you are a part of the thousands of students who have been here during the past two centuries, it makes you determined that you will work hard and well in order that you may do everything in your power to maintain the standard bequeathed to you by your predecessors. When you turn your mind to the past as you wander round Guy's you experience the same sensation that comes over you when you are in an ancient college or cathedral, and you resolve that, come what may, it shall not be your fault should anything occur to imperil the reputation that has been maintained for two hundred years.

Some in front of me are newcomers, so perhaps you will excuse me if I point out why this School is famous. Many geniuses have adorned it, some as Bright, Addison and Keats belong to the select class of immortals. The names of others will last a long time. There was that prince of administrators, that enthusiast, the younger Harrison, for fifty years Treasurer, who did more for the School than anyone. There is—happily not was—Mr. Bonsor, our late Treasurer, who rescued the Hospital from its financial difficulties of the eighties in the last century.

Our first physician, Dr. Jurin, secretary to the Royal Society, President of the Royal College of Physicians, was a classic, a distinguished mathematician, a physician and a physiologist—he accurately determined the specific gravity of the blood—and he may be said to have set a standard. There followed such men as Astley Cooper, that bold surgeon and indefatigable worker, Gull, who first told us of myxœdema and anorexia nervosa and laid the foundation of our knowledge of arterio-sclerosis, Wilks, who originally described visceral syphilis and wrote his classic on Pathological Anatomy, Fagge, the author of the best book on Medicine ever written—should you think you have discovered a new fact in either of these subjects look in these two books, you will find it there—Hilton, to whom we owe that beautiful essay entitled "Rest and Pain," Hodgkin, after whom a disease was named and who was the earliest to describe aortic disease, Swaine Taylor, who created the Department of Medical Jurisprudence in this country, Fox, the first dentist to write a scientific book on the teeth, and his famous successor Bell. I might spend a whole afternoon giving an account of the scientific activities of the staff of Guy's.

If you wish to be an expert on microscopes you need only study lenses, but to be a good physician or surgeon you must be interested in men and their doings, therefore it is worth while to see how far

Guy's has been associated with people who have made their mark outside our profession.

Keats I have mentioned. That great Churchman and thinker, Frederic Dennison Maurice was Chaplain here and there used to come to dinner with him Carlyle, Sterling and others of that literary set. Browning attended lectures on physiology given by Blundell, who foreshadowed the doctrine of evolution. Tupper, the draughtsman who succeeded that artistic genius Hurst whose water colours of disease are among the treasures of our Museum, was a member of the Pre-Raphaelite Brotherhood, he assisted in the birth of and contributed to the "Germ." Hinton the metaphysician was aural surgeon, and the greatest artist the world has seen in the art of wax modelling, Towne, worked here for more than fifty years.

But you will say, geniuses are born not made, what is the use of this to us—perhaps there is not a single genius in the theatre this afternoon. Surely the remembrance of the brilliance which has been cast upon Guy's by these men will stimulate each of you to strive to contribute to the continuance of the illumination even if it be only by a rushlight.

Further there are characteristics of Guy's that we can all practise, they are go-a-headness, thoroughness, self-reliance and independence. These are seen in many ways.

Some years ago it was borne in upon the authorities that inadequate provision was made for the dental treatment of the millions of poor in the neighbourhood, consequently the present large and successful Dental Department was founded. At a time when the importance of Morbid Anatomy was hardly recognised it was appreciated here, therefore universal complete post-mortem examinations and records were introduced and a museum, which has become one of the best there is, was started. Hodgkin threw all his enthusiasm into it, Towne adorned it with his priceless models. As early as 1798 the staff saw that the reporting and publication of cases would lead to a better knowledge of medicine, accordingly they began the issue of volumes entitled "Medical Reports and Researches." In 1836 the Clinical Report Society of Guy's was founded and students were encouraged to make reports of cases. This society naturally ceased to exist when all ward clerks had to write reports. It was considered that reports destined to form the basis of Clinical Lectures should be prepared by those who had had experience in the writing of them. Hence the appointment of "Clinicals" came about. This office is peculiar to Guy's, you all know how it is prized, how valuable is the medicine you learn from it and how it teaches you responsibility. One of the chief aims in the teaching here has always been to develop in students the power to assume responsibility. The best part of a student's career is when he holds the appointment of "Clinical" and certainly the happiest part of a physician's career is when he is on duty in the Clinical Wards. I have always said that the ideal position for a life's work would be to be permanent physician in charge of the Clinical Wards, but such a thing could not be, for the experience gained is far too valuable to be in the hands of one man.

The publication of the "Guy's Hospital Reports" was begun in the same year and still continues, we have now reached Volume 72. No other Hospital Reports have anything like the length of existence, the fame and width of circulation, they are known over all the world. The "Guy's Hospital Gazette" has been in existence for fifty years, and the Bodleian has asked for a complete set of the "Guyoscope."

The value of discussion was perceived as long as a hundred and fifty years ago, and the Guy's Hospital Physical Society, the first noteworthy medical society and the most important medical society of its day was founded in 1771. Jenner read his account of vaccination before it. Even non-medical men contributed, for we find Thelwall, the radical, reading a paper on Animal Vitality, which was discussed for six evenings. In 1836 an obstetrical society was started within these walls. It was here among English hospitals that antiseptic surgery was first introduced systematically, Sir Henry Howse being the surgeon who did it.

The energy of Guy's men in promoting knowledge penetrated the outside world. They were largely responsible for the foundation of the Medical Society which still flourishes. Saunders was the first President of the Royal Medico-Chirurgical Society. Babbington founded the Geological and Hunterian Societies. In the formation of the first he was helped by our chemist Aikin, who with his sister, Mrs. Barbuld, wrote "Evenings at Home." Babbington Junior was the first President of the Epidemiological Society. Bell was one of the founders of the Zoological Society, he was President of the Linnean Society and first President of the Ray Society. The Linnean Society was founded by Sir Edward Smith, the Pathological by Dr. Edward Bentley, and Dr. Guy was first President of the Statistical Society. All these were Guy's men.

Activity and a desire to make this Hospital and School the best of their kind are the chief components of the atmosphere breathed here, not only by the teachers, but by everybody connected with the place. There is no finer Nursing Home than that which you see every day, and we have always been pioneers in advancing the welfare of the nurses. As I walked down the Colonnade I was reminded, by the placards there, of the Ladies' Association, the original of many similar bodies, it now has branches all over the country, it has supplied thousands of garments to the patients and has collected enough money to endow several cots and to contribute to the upkeep of many beds.

The recent discussion in the *Referee* shows that the oldest Rugby Football Club is ours. Dr. Pavy gave us a gymnasium in our own walls. The first Clubs' Union with its playing ground was started here and the earliest building designed as a Residential College and Club, attached to a Medical School, was the red brick structure the other side of Maze Pond.

I feel ashamed of what I have said, it is too much like blowing one's own trumpet, but it is not said with the vulgar, despicable object of self glorification. I started with a proposition, that this is a large, ancient, and famous School, necessarily I have had to bring forward evidence of its truth. I trust I have convinced you and have shown you that Guy's is famous not only for the eminence of those who have preceded us, but for its tradition of energy and thoroughness. It is because of their energy, thoroughness and self-reliance that Sir Samuel Wilks used to say that "Guy's students are a special type." Always remember the tale of Addison. He had seen a case in the wards and had gone home, in the middle of the night the nurse on duty was astonished to see him walk into the ward; after he went to bed he recollected he had forgotten to satisfy himself that the patient had not a hernia, consequently he got up and came at once to re-examine the case.

Remember that your having become Guy's men entails upon each of you the duty of also becoming one of those to whom Hodgkin alluded when at the close of his opening Lecture he said, "I shall conclude by assuring you that it will be my constant aim—whether I may be fortunate enough to reach the mark or not—to co-operate with those who are strenuously endeavouring to render the School of Guy's Hospital the first Medical School in the kingdom."

Throughout your life do this and always have in remembrance your predecessors. Whether your work is in the practice of your profession, in the laboratory or in administration, let your performance be such that you would not be ashamed to submit it to a jury all of whom are or have been Guy's men. Let your conduct bear the same test. Then will you experience the feeling which of all others is to be desired, namely that you are a member of a happy band of brothers who have been educated at this School and have inherited its traditions.

THE CHAIRMAN:—Gentlemen,—I am sure that you will wish that I should, on your behalf as well as on my own, express to Sir William Hale-White our appreciation of his coming here to present the Prizes, and our best thanks to him for the really delightful speech which he has just delivered to us. I think you will agree with me that that address has shown not only his vivid interest in Guy's at the present moment, but that he has found time to saturate himself with the knowledge of old Guy's and its doings. I can only hope that it is not only to-day that we shall have had the pleasure of listening to that address, but that the time may come in the future when we shall have the pleasure and opportunity of reading both something of that address and more stories of old Guy's, which I hope Sir William Hale-White will find time to put into print. (Applause.)

Gentlemen, he has spoken about the atmosphere of Guy's and in the few minutes I am going to speak I would like to say something about that, because I am sure that all of you know that at the present moment Guy's, as well as other Hospitals, like everything else, are going through very critical days. There is a very great principle at stake; the voluntary principle. But it is not only the voluntary principle which is at stake, it is not only the efficiency and the solvency of our great Hospitals, but it is the spirit, I believe, which animates those Hospitals which is at stake if we are to give up that voluntary principle. (Hear, hear.) I am only a layman but I, at any rate, can speak as a patient, and I do know that the atmosphere which surrounds a sick bed can exercise an influence either to retard or to accelerate the progress of the patient. I am convinced that this voluntary spirit, which has become the guiding principle of our Hospitals not only affects the Hospitals but the patients who come into them. The spirit I mean is the kind of spirit which exists at the present day between Guy's and the Borough, because the people of the Borough who come into our Hospital know that Guy's are animated by that spirit which comes from joint endeavour through the desire of all connected with Guy's to work for the honour and the credit of Guy's, and for the pleasure they feel and take in the work connected with the Hospital. I am myself quite sure that that spirit will not exist to the same extent if Hospitals become Government Institutions. It would not flourish if it was bound by formality and hedged in with the rigidity of custom which, I believe, you would get in such institutions. Therefore I do venture to say that it is up to everyone of us to do what we can to maintain the voluntary principle and work at the present moment for the great appeal which has been made on behalf of the Hospitals. I think I have said before, but I should like to say again and to impress upon you who are going out to take up your profession in life this: That in every profession and in every walk of life you may have knowledge, you may have efficiency, but knowledge and efficiency are not of really the greatest value unless you have the spirit of humanity, the human spirit of sympathy behind it. It is the human factor, after all, which counts most of all in everything in life.

I should like to take this opportunity, if I may, as Treasurer of this Hospital, to thank all the students and the nurses for the really great work which they did for the Hospitals on Empire Day, and for the splendid collection which they then made. I may say that you all worked with the enthusiasm and zeal of the hunter and with the sagacity of the stag. I believe that no one passed between London Bridge and the City who was not attacked by either a Guy's man or a Guy's woman, and also I know the good work which was done in Epsom on Derby Day. That was a very much harder task, because a great many people had already contributed to the Hospitals and perhaps a large number of people there were taken up with abstruse financial calculations. (Laughter.) If they were upset for a moment or two it would have entirely destroyed their hope. But I noticed this: that from the time I left London right down to the Course there was a greater preponderance of Guy's women and men endeavouring to pick one's pockets than of any of the other Hospitals in London. I can assure you, gentlemen, that we are deeply grateful to you and to all the ladies who worked for Guy's, not only for the work which you did, but because we believe that behind it and animating it was the spirit and desire to maintain that great voluntary principle under which Guy's has so greatly flourished. I now ask you to give a most cordial vote of thanks to Sir William Hale-White for coming here to-day and to allow me to assure him, on your behalf and in my own name, that the more often he comes to Guy's and speaks to us, the better we will be pleased. (Loud applause.)

DR. FISON, who on rising to speak was most heartily cheered, said: I am sure that no one of us would wish to leave this Hall without extending our warmest thanks to Lord Goschen not only for occupying the Chair and for keeping us in such excellent order, with the assistance of Sir William Hale-White, but for the words of solid wisdom that he has poured out upon us during the last few minutes. Many of us know Lord Goschen so well now, we have attended so many meetings here at which he has presided, that we have come to regard him as one of ourselves; that is, as the idealisation of our combined better selves. (Laughter.) I have alluded to the kind, the genial manner, in which Lord Goschen has presided this afternoon. But we have indeed behaved so nicely that we have only aroused his *suaviter in modo*, and I can assure you if we had behaved otherwise we should very soon have become acquainted with his *fortiter in re*. But Lord Goschen will be the first to acknowledge the truth of what I say. There is something that we can give him that he will deeply value. I understand that in the Roman Church a man who is a priest is always a priest. Whatever his life, however degraded it becomes, he can find no means of seceding from the Church. Though, happily, the parallel does not run, a man who is a Guy's man is always a Guy's man, and by no means should he divest himself of the responsibilities and privileges that that entails. As Sir William Hale-White so admirably pointed out, you have inherited the traditions of one of the greatest Medical Schools. It is up to you to transmit those traditions, ennobled it may be, if it is in you to do so, to those who follow you. Some of us, I know, are modest. All of us are more or less conscious of, we will say, one another's shortcomings, but whatever our modesty and whatever our shortcomings, we are the inheritors of the traditions of this great Medical School. It is, as I have said, a position of great responsibilities and great privileges. The responsibilities you endeavour to bear in your work throughout this Hospital, and I am only going this afternoon to ask you to use one of your privileges, and that is to thank Lord Goschen in the heartiest manner worthy of Guy's not only for his kindness to you, for the interest he takes in you, but for the keen interest he takes in this School in general. And that is, I am sure, something you can give Lord Goschen that he will appreciate. (Applause.)

DR. J. FAWCETT: I am not going to make any further speech, but quite informally to second the two votes of thanks, one to our Treasurer, Lord Goschen, because we know we could not possibly have a better Treasurer. We all appreciate everything he does, and it gives us very very great pleasure to see him. And secondly, the vote of thanks to Sir William Hale-White, because you could not have a better representative of Guy's men and Guy's Hospital and Medical and Dental Schools to tell us about our institution. I therefore ask you to support this vote of thanks and to give first three cheers for our Treasurer and then three cheers for Sir William Hale-White.

The cheers to Lord Goschen and Sir William Hale-White having been most heartily given,

THE CHAIRMAN said: Gentlemen, the very inadequate idealisation of your combined selves thanks you. (Laughter and applause.)

The proceedings then terminated.

Medallists and Prizemen. June, 1922.

Open Scholarships in Arts.—Russell Claude Brock, Christ's Hospital, £100. Arnim Fitz-William Horatius Stewart, Private Study, £50.

Scholarship for University Students.—(*War Memorial Scholarship*).—Bernard Graham Scholefield, B.A., Christ Church, Oxford, £80.

Entrance Scholarship in Dental Prosthetics.— September, 1921. Vivian Russell Estment, £30.

Junior Proficiency Prizes.—Ivor Pritchard Spurrell, £20. Douglas William Claridge Northfield, £15. William Francis Roper, £10. Harold John Selby, Certificate.

The Beaney Prize for Pathology.—David Sydney Davies, £34.

The Michael Harris Prize for Anatomy.—Ivor Pritchard Spurrell, £10. Douglas William Claridge Northfield, Certificate.

The Wooldridge Memorial Prize for Physiology.—William Francis Roper, £10. Douglas William Claridge Northfield, Certificate.

Dental Prizes.—Senior Prize in General Subjects. —Barney Rubinstein, £10. John Freeman Allin, Certificate.

Prize for Operative Dental Surgery.—Kenneth Gordon Sharvill, £10. Gordon Beamish, Certificate. Oswald Howard Maynard Woodbridge, Certificate.

The Golding-Bird Gold Medal and Scholarship in Bacteriology.—Louis Forman, Gold Medal and Scholarship. John Harrop Marshall Lloyd, Certificate. Edward Horace Richards, Certificate.

The Treasurer's Gold Medal for Clinical Medicine. —Maurice Elgie Shaw.

The Treasurer's Gold Medal for Clinical Surgery. —Frederick William Widgery.

Pass List.

University of Cambridge.

SECOND M.B.—PART I.

Anatomy and Physiology.

L. E. Houghton. W. J. Montague.
D. M. Lang. H. G. Wimbush.

THIRD M.B.—PART I.

Surgery, Midwifery and Gynæcology.

C. G. Taylor.

Medicine, Pathology and Pharmacology.

H. W. Taylor. L. S. Fry.

M.D.

B. E. Jerwood.

Change of Address.

E. Deane, Penmarch, Milford-on-Sea, Hants.

F. O. Newman, "Westway," Knowle, Warwickshire.

H. A. A. Pargeter, Stamford Lodge, Sevenoaks.

R. P. Marshall, M.R.C.S. (Harvey and Marshall), The Manor House, Goudhurst, Kent. (Tel. Goudhurst 7.)

O. G. Morgan, M.Ch., F.R.C.S., 7, Devonshire Place, W. 1.

J. A. Berry, Napier Hospital, Napier, New Zealand.

T. B. Johnston, M.B., 14, St. Thomas's St., S.E.1.

J. A. Berry, Napier Hospital, Napier, N.Z.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

London University Liberal Society.

DEAR SIR,—We trust that you will allow us to draw the attention of those among your readers who are graduates of the University of London, to the fact that Professor A. F. Pollard, Litt.D., F.B.A., has agreed to stand at the next election, provided that sufficient support be forthcoming.

Professor Pollard holds a long and distinguished record of work for the country as well as for the University. He became Professor of Constitutional History at University College in 1903; since 1907 he has been University Professor of English History and since 1911 Chairman of the Board of Studies in History. He was a member of the Senate from 1910—1915. The foundation of the Institute of Historial Research last year was due to his initiative and energy, and he is now Chairman of the Institute.

Since 1908 he has been Research Fellow of All Souls College, Oxford. He is a member of the Master of the Rolls Committee on Public Records, and of the Royal Commission on Historical Manuscripts. In 1917—18 he was a member of the Committee appointed by the Foreign Secretary (Mr. Balfour) to report upon the juridical and historical aspects of a League of Nations. In 1920 he became a Fellow of the British Academy to the Council of which he has been co-opted to fill the vacancy caused by the death of Lord Bryce.

Among his numerous works may be mentioned, *Factors in Modern History; The Commonwealth at War*, a collection of papers and addresses (1914—17) which are specially interesting as evidence of his great powers of political prescience. *A Short History of the Great War* (1919), and the recently published *Evolution of Parliament.* He is an historian of international reputation, alike for ripe scholarship and for balanced judgment; and we feel confident that he would not only do justice to the position which the University occupies in the world of thought, but would be a factor of inestimable value in determining the policy of the Country.

The fact that he would be an active member of the House of Commons, untrammelled by party pledges and traditions should ensure the support of a large number of University electors who are naturally reluctant to vote for pledge-bound items of a party.—We are, Yours faithfully,

M. WEINBREN (Guy's), President.
F. MOULD (U.C.L.), Hon. Treasurer.
C. R. COOKE-TAYLOR (U.C.H.), Hon. Secretary.

41, Parliament Street, S.W.1.
27th June, 1922.

Toxic and Infective Jaundice.

CLINICAL LECTURE BY DR. J. A. RYLE.

GENTLEMEN,—Of the cases admitted to hospital with jaundice as a prominent symptom the majority are suffering from some form of obstruction to the main bile-passages. Gall-stones and carcinoma of the head of the pancreas are among the commoner causes of such obstruction, while more rarely the pressure of tumours or malignant metastases may be shown to be responsible. Jaundice is also sometimes present, though not as a leading symptom, in a smaller group of cases in which gross circulatory, mechanical or inflammatory changes in the liver have occurred with the production of an intrahepatic compression or occlusion of the ducts. The jaundice accompanying the hepatic engorgement of advanced cardiac failure in mitral disease, and the tinge of icterus sometimes seen in the terminal stages of Laennec's cirrhosis may perhaps be cited as examples of this type, and a spreading infective cholangitis may similarly produce the symptom. These conditions, however, it is not my purpose to discuss. Local infection or intoxication obviously plays a part in many of them, but under the actual heading of "toxic and infective jaundice" we range quite another class of cases, in which, in consequence of some more general poisoning, various processes have conspired to impair the function of the liver-cells and so to give rise to jaundice and frequently to other and graver manifestations.

The poisons which operate in this way may be chemical poisons introduced from without, bacterial or protozoal poisons, or endogenous poisons resulting from causes at present unexplained.

The war added very considerably to our knowledge of toxic and infective jaundice, work in the munition factories, on the one hand, and service in the field, on the other, providing cases in such numbers as to call for special researches and investigations. But although the incidence of these diseases was conspicuously increased by war-conditions they do occur sporadically in peace-time with sufficient frequency to necessitate our making their acquaintance. Moreover their study is full of clinical and pathological interest.

As a very rough indication of the peace-time incidence of toxic and infective types of jaundice, I may cite my own small experience which includes 11 cases since the middle of 1919; 9 of these were seen at Guy's. This contrasts with 55 cases of one type of infective spirochætal icterus alone which passed through my own hands during a period of a few months in France. Of the 11 cases seen since the war, 4 were due to chemical poisons, 3 being cases of salvarsan poisoning and one probably due to trinitrotoluene. Two were cases of toxæmic jaundice accompanying the final phase of a pregnancy. One was a case of acute yellow atrophy. One was a case of hepatic syphilis; one was a case of lobar pneumonia; the remaining two cases were, I believe, cases of spirochætal jaundice or Weil's disease. I have not included cases of Addison's anæmia or acholuric jaundice, the place of which disease in this group we will discuss later. (Nor have I mentioned catarrhal jaundice, to which I will also refer later on.)

A feature of the toxic and infective jaundices worthy of note is that in spite of the diversity of the causal agents, the resultant clinical pictures are very closely similar, and the end-results in the fatal cases almost indistinguishable. It will be well, therefore, before proceeding to a discussion of clinical features to review briefly the common pathological processes at work and underlying the production of the icterus.

I should like you to consider first of all the question whether there exists any example of a jaundice which is not really an obstructive jaundice. You will find reference in the text-books to hepatogenous and hæmatogenous types of jaundice and to combined or hæmo-hepatogenous types, the terms implying that jaundice may have its origin in liver disease, in blood-destruction or in a combination of these processes. I am doubtful whether we have sufficient grounds for maintaining that there are any true instances of a purely hæmatogenous jaundice, and it seems to me that to contend that all jaundice is the result—in part at any rate—of obstruction either within or outside the liver is reasonable and serves at the same time to simplify our appreciation of the symptom.

To take examples of diseases in which the jaundice is presumed to be hæmatogenous, we have certain acute hæmolytic infections in the

course of which a faint icterus is not uncommonly developed; we have acholuric jaundice; and we have pernicious anæmia. Can it be said in any of these that the liver is normal? In many cases coming to post-mortem examination the liver cannot be passed as normal, but even if it were so, do we not have to admit that in association with rapid blood destruction there must in all probability be increased viscidity of the bile, and that this alone may give rise to a virtual obstruction in the smaller ducts? Experimentally it has been shown in animals that the production of jaundice by the administration of hæmolytic poisons like toluylenediamine is accompanied by a striking increase in the viscidity of the bile which clogs the bile-canaliculi, though catarrh of the bile-ducts may perhaps be contributory.

I shall ask you, at any rate for the moment, to regard all jaundice as obstructive, only remembering that the obstruction may be extra- or intra-hepatic, but that in the latter case disease of the liver itself or of the bile-channels is not necessarily a main factor in causing the jaundice.

The following are factors which may contribute to the production of an intra-hepatic jaundice in the course of the general intoxications and infections under discussion.

Firstly, there is direct damage to the liver cells, of which we have undoubted post-mortem evidence in such conditions as phosphorus and arsenical poisoning and in so-called acute yellow atrophy of the liver, and rather less striking evidence in the spirochætal infections in which the liver may be found histologically to be crowded with spirochætæ or to show, as in spirochætosis icterohæmorrhagica, some leucocytic invasion—that is to say in which there is evidence of a true hepatitis. It is noteworthy that the leucocytic invasion in spirochætosis icterohæmorrhagica is especially around the fine bile-canaliculi.

Secondly there may be a catarrh of the intra-hepatic bile-passages.

Thirdly there may be destruction of red cells with increased formation of bile-pigment and increased viscidity of the bile; and fourthly this increased viscidity of the bile may, in the febrile diseases or as the result of vomiting and diminished fluid-intake, be further augmented.

It will be apparent that the importance of each of these factors must vary with the causal agent. In phosphorus and arsenical poisoning for instance the specific damage to liver cells, sometimes passing on to necrosis, is probably the main factor; in spirochætal jaundice and yellow fever it is a specific hepatitis; in certain septicæmias and those cases of Addison's anæmia in which the symptom occurs the hæmolysis with overproduction of bile-pigment is probably of major importance.

The causal agents, as I have already mentioned, may be classified into chemical, bacterial, protozoal, and unknown endogenous poisons. Of the chemical poisons chloroform, arsenic, phosphorus, tetrachloretane, employed in the manufacture of aeroplane "dope" (a liver-poison), and trinitrotoluene employed in the manufacture of high explosive (a hæmolytic and a liver poison), have received special attention and with them it is convenient to group snake-venom which is a further example of an extraneous hæmolytic poison capable of producing jaundice.

Of the bacterial poisons the hæmolytic toxins of certain streptococci and some pneumococcal infections are known originally to give rise to jaundice. Whereas in the streptococcal infections hæmolysis is frequently present, in pneumococcal the jaundice is more probably due to hepatitis.

Of the protozoal infections, yellow fever, spirochætosis ictero-hæmorrhagica, or Weil's disease, malaria, relapsing fever and syphilis are the best known. All of these, it is worthy of note, are spirochætal infections with the exception of malaria, and their study leaves one with the impression that spirochætæ have some selective affinity for liver tissue. With regard to ordinary catarrhal jaundice, recent work seems to suggest that this, too, is due to an infective hepatitis rather than to obstruction by catarrhal swelling of the main ducts alone, but the passing of clay-coloured stools is, I think, a point in favour of the presence of such obstruction. Into our mysterious group which we class as due to unknown endogenous poisons fall the toxic jaundice of pregnancy and the condition known as acute yellow atrophy, acute necrosis or icterus gravis.

I propose to take a few examples from these groups to describe to you clinically.

From the chemical group I shall take arsenical poisoning because recent years have

added a good deal to our knowledge of the condition and because it is the one which you are perhaps the most likely to encounter, though increasing care in the observation of cases coming up for treatment and during the course of treatment with salvarsan preparations and improved standardization and judicious dosage have already made it a rare occurrence and will be certain to make it rarer yet.

From the protozoal group I shall select spirochætal jaundice (Weil's Disease), as it has been my good fortune to be able to study that disease in bulk. The toxic jaundice of pregnancy and acute yellow atrophy occurring apart from pregnancy are so similar and so obscure that they may well be discussed together. In the septicæmias and in Addison's anæmia jaundice is merely an occasional and subsidiary symptom and only calls for special mention here as instancing the variety in which hæmolysis plays the leading part.

Poisoning with arsenic has long been known to produce a certain train of symptoms, the more important of which are symptoms of gastro-intestinal irritation, peripheral neuritis, an acute exfoliative type of dermatitis and a chronic dermatitis with pigmentation. It was not, however, until the introduction of intensive methods of treatment of syphilis with arsenical compounds that it became possible to study in the human the graver effects of arsenic on the viscera. Some have tried to argue that these effects are attributable to the benzol group in the cases of poisoning from salvarsan preparations, but I think the balance of evidence is strongly in favour of the arsenic being the noxious element.

In a series of cases reported in the *Lancet* of April 10th, 1920, by G. S. Strathy and others, it was shown that symptoms followed after numbers of injections varying from two to fourteen and that the average period which elapsed between the last dose and admission of the patient for toxic symptoms, was in the neighbourhood of forty days, though periods much shorter and much longer than this were recorded. Jaundice was throughout the series the most prominent symptom. It lasted on the average four weeks in the cases which recovered though the total period of convalescence was often very much longer. The liver was temporarily enlarged in some cases; in others there was not only reduction of liver dulness, but a decrease in the size of the liver shadow as demonstrated by X-ray. The stools were obviously bile-stained, sometimes for short periods clay-coloured. Other symptoms included albuminuria, headaches, epigastric pain and fulness, vomiting, a coated tongue and loss of appetite. Peripheral neuritis and dermatitis were also occasionally present. In the fatal cases stupor, delirium and hæmatemesis were recorded. There were eight deaths in fifty-eight cases. The post-mortem findings were those of acute yellow atrophy of the liver.

I think it is noteworthy that we have in this type of toxic jaundice as well as in the other types very frequent evidence of renal as well as hepatic damage. In some cases the renal damage may possibly be a factor in determining the course of the disease. In mild cases the distinction from catarrhal jaundice may be very difficult; for safety, I think it should be the rule to regard any jaundice arising during or shortly after a course of treatment with arsenic compounds as due to the arsenic. The presence of albumen is a point in favour of arsenical hepatitis.

Spirochætal jaundice, spirochætosis icterohæmorrhagica, or Weil's Disease, was, prior to 1914, a disease of entirely unknown ætiology. In 1914 and 1915 the Japanese, in whose country, especially in the mines, the disease is very rife, were able to demonstrate a spirochæte in the blood and organs of guinea-pigs inoculated with the blood of human patients. Later they traced the infection to rats. In 1917 an epidemic of jaundice with fever and hæmorrhages, and other symptoms which I shall describe, appeared in the Ypres salient, and Adrian Stokes, pathologist to the 2nd Army, was able to confirm the whole of the work done by the Japanese, to find a high proportion of infected rats in the sectors from which the bulk of the cases came, to show that an infected guinea-pig could be cured by the serum of a recovered human patient, and to show on some of my cases, which I had suspected on clinical grounds of having the same disease, that a non-icteric type of the fever also occurs. At the same time the morbid anatomy and histology was carefully worked out in the fatal cases and the experimental animals. The disease is sudden in onset. The incubation period is between a week and a fortnight. The path of infection is probably by the mouth and due to the rats urinating on the food which they leave unconsumed, as spi-

rochætæ can be demonstrated in their kidneys and urine.

At the same time the skin is a possible site of infection, as guinea-pigs can be inoculated, not only through abrasions, but even through the intact skin.

pears and rapidly deepens to a lemon or orange tint. The mouth and skin are very dry, and the patient looks extremely ill. Red cells and casts and acetone, in addition to bile-pigment and albumen, are often present in the urine. Epistaxis and hæmoptysis are common and

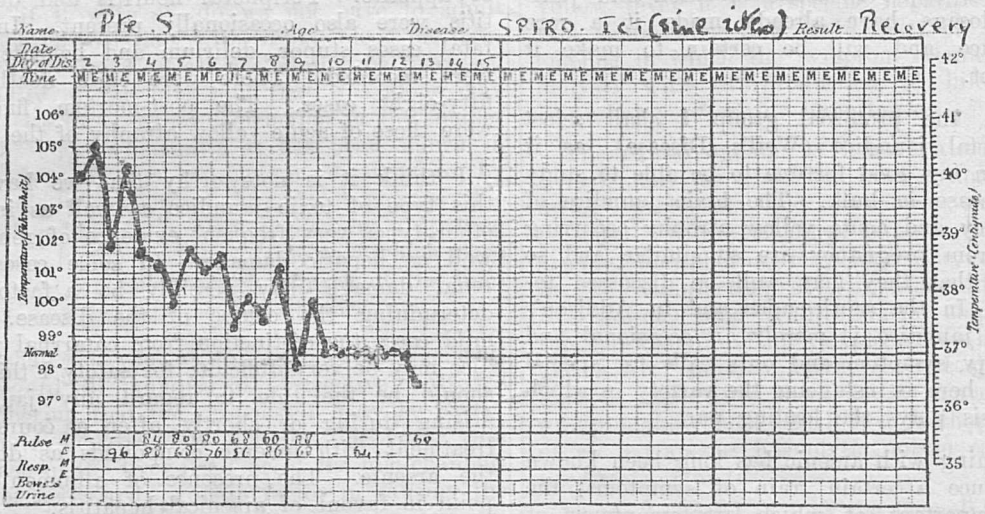

FIG. I.

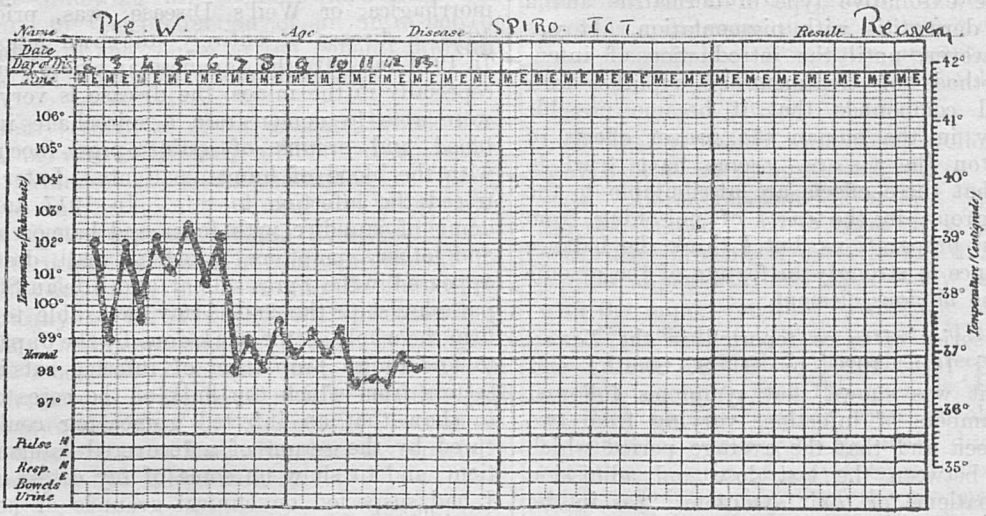

FIG. II.

The early symptoms are high fever up to 104° or 105°, prostration, intense aching pains in the muscles and limbs, vomiting, herpes of the lips, nares, and chin, which rapidly becomes hæmorrhagic, injection of the conjunctiva, and albuminuria. On the third or fourth day in the majority of cases the jaundice appears and rapidly deepens to a lemon or orange tint. The mouth and skin are very dry, and the patient looks extremely ill. Red cells and casts and acetone, in addition to bile-pigment and albumen, are often present in the urine. Epistaxis and hæmoptysis are common and more rarely cutaneous and bowel hæmorrhages occur. From the frequent association of jaundice and hæmorrhages the disease derives its name of spirochætosis "ictero-hæmorrhagica." The fever lasts about ten days and may terminate by lysis or crisis (see Figs. I. and II.). Relapses sometimes follow.

The spleen was never palpable in my cases, and was not found to be enlarged at autopsy, though in the book descriptions of Weil's Disease it is stated to be enlarged. In a small proportion of cases the liver was definitely enlarged and slightly tender. The fæces are normal in colour or actually bile-stained and rarely typically clay-coloured. In the fatal cases the temperature became subnormal a day or two before death, and stupor or rambling delirium set in with incontinence, twitching and in some cases Cheyne-Stokes breathing.

You will note ,therefore, that in the grave cases there is little or nothing to distinguish between spirochætal jaundice and delayed arsenical poisoning following the administration of salvarsan preparations. In both there is jaundice, albuminuria, a tendency to hæmorrhage, stupor and delirium. In spirochætal jaundice, however, I have never seen the liver reduced in size, nor at autopsy does it show the wrinkled capsule or characteristic appearances on section met with in arsenical poisoning and acute yellow atrophy. The disease in the guinea-pig is clinically exactly similar to the disease in man, but is more rapidly and certainly fatal. Apart from the discovery of the spirochæte in the liver and blood of the guinea-pig there is one very pretty and diagnostic sign when the body of the animal is opened. The lungs are seen to be dotted and mottled with hæmorrhages which give to the two pale organs lying in situ the appearance of some rare butterfly. The mortality of the disease in France and Belgium was only 5·4 per cent., but in Japan and other foreign epidemics it has been much higher, and sometimes as high as 30 per cent.

Research on this disease at once turned attention again to the study of yellow fever, for clinically the two diseases are almost identical. I well remember, when confronted with the first cases, turning to my volume of Osler for descriptions of infective febrile jaundice, and wondering whether yellow fever had perhaps arrived to add to the horrors of the Ypres front, though the absence of Stegomyeia (the mosquito which carries yellow fever) from that neighbourhood made this improbable. Excepting that it is still more fatal and that hæmatemesis, or "black vomit," is a more common accompaniment, the description of yellow fever would answer for that of spirochætosis icterohæmorrhagica. Since the war Noguchi has demonstrated an almost identical spirochæte in yellow-fever cases.

The prevalence of spirochætosis icterohæmorrhagica during times of war, and among sewage-workers and slaughter-house men is explained by the association with the rat which those occupations involve. The two cases of probable spirochætosis which I have seen in this country were that of a woman under the care of Dr. Hurst in 1919, whose husband, a sewage worker, had just died of jaundice with coma, and who herself presented features of a mild infective jaundice, and another case recently, also under the care of Dr. Hurst, of a severe spirochætal infective jaundice in a patient whose premises had recently been overrun by rats. It is unlikely that the disease will crop up in epidemic form in this country, but as the ordinary London rats are shown, in a small percentage of cases, to carry the spirochæte, occasional infections are by no means impossible.

The differential diagnosis has to be made from simple catarrhal jaundice in which the absence of high fever and constitutional upset in the initial phase of the illness, and of the severe pains and albuminuria and herpes are usually sufficient to allow of the distinction; from the enteric group infections in which jaundice is sometimes a complication; from those rare instances of pneumonia complicated by jaundice; from other protozoal infections, and from an extra-hepatic obstructive jaundice (complicated by infection) in which local symptoms will probably have been present at some period of the disease. If seen in the febrile stage the pyrexia itself, as well as the history, should help to exclude a toxic as opposed to an infective jaundice. Inoculation of a guinea-pig before the fifth day may clinch the diagnosis.

I have here some illustrations of the spirochætæ drawn from Levaditi preparations illustrating their morphology, and also some charts illustrating the pyrexial curve in man and the experimental animal. It is, I think, worth mentioning that we found in our cases no increase in the fragility of the red cells and no anæmia, and as in the fatal cases there was no gross damage to liver cells, I think it is fair to assume that the icterus was neither due to hæmolysis nor to actual liver destruction, but rather to a true hepatitis; of this the spirochætæ in the liver sections of the animal specimens and the leucocytic infiltration in the human specimens gave further evidence.

A brief description of two cases seen within a short period of each other in 1920, will suffice to give you a mental picture of the toxic jaundice of pregnancy and acute yellow atrophy.

The first was a primipara, aged about 35. Her doctor stated that she was well up to the time of her confinement, that the labour had been rather prolonged, but that the amount of chloroform used was not at all excessive. Within a few hours of delivery the patient became drowsy and within twenty-four hours jaundice developed and drowsiness turned to stupor. When I saw the patient she was quite unconscious and incontinent and was definitely jaundiced. I thought the liver dulness was diminished. She only survived a few hours and unfortunately a post-mortem examination was not obtained. Her doctor was of

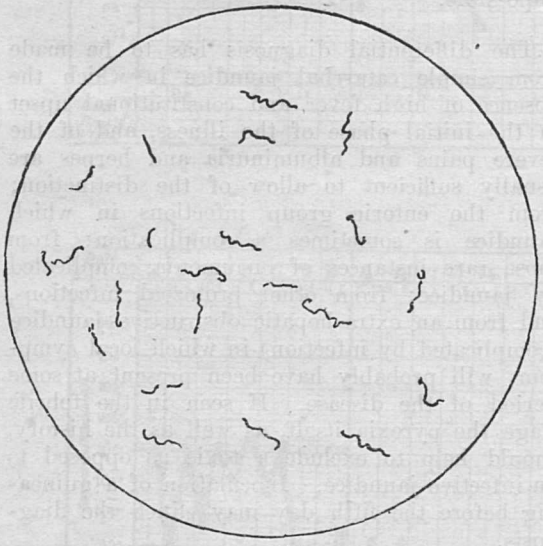

FIG. III.

Diagram to represent one field of liver in guinea-pig. The organisms are not drawn to scale, but are to represent shapes and forms seen in a field.

the opinion that the case might be one of delayed chloroform poisoning, but in view of the small amount of chloroform used (the exact amount I have forgotten) and of the fact that chloroform is usually well tolerated during parturition I rather favoured the view that the case was one of those unexplained toxæmias of pregnancy akin to eclampsia. I only remember seeing one similar case just before full-term which also ended fatally and in which the liver was not found to show naked-eye evidence of atrophy at autopsy.

The case of acute yellow atrophy can be very shortly described. It was that of a woman between fifty and sixty years of age who had been vaguely indisposed for some weeks without any localising symptoms. A few days before admission to Guy's she became drowsy and deeply jaundiced, and on admission was semi-comatose and showed a diminished liver-dulness. She was admitted to the surgical wards, having been sent up for admission as an obstructive jaundice, but the history, the the coma and the complete absence of any localising signs in the gall-bladder region and the deviation of the icterus, which was much shorter than that usually obtaining in cases of pancreatic carcinoma, helped to differentiate her as a case of acute yellow atrophy; the post-mortem examination subsequently showed the diagnosis to be correct. Vomiting, hæmorrhages and albuminuria are commonly present in acute yellow atrophy, and leucin and tyrosin have been described as occurring in the urine, but I have never seen them demonstrated. The condition runs a very varying course of days or weeks and is almost invariably fatal. Its cause is quite unknown, but the assumption is that some autolytic poison is developed which has a selective action on liver cells.

Much of my clinical description will seem to you to have been mere repetition, but perhaps this may serve to emphasise the very close similarity which exists, especially in the grave cases, between all types of toxic and infective jaundice in which liver intoxication plays the major part. In all of them, in addition to the main symptom, there is a tendency to hæmorrhages, vomiting, albuminuria, drowsiness, and coma, and we may in fact accept these as the symptoms of advanced acute impairment of hepatic cellular function. In all of them general symptoms predominate, and local symptoms, as in gall-bladder disease, are absent. They are further distinguished from extra-hepatic obstructive jaundice by the fact that the stools are often normal in colour or actually bile-stained instead of clay-coloured. If stupor appears, the prognosis becomes almost hopeless in all of them.

It is a matter for speculation whether the hæmorrhages are an expression of the jaundice or of the same toxæmia which is producing the jaundice. In spirochætosis icterohæmorrhagica hæmorrhages occur in the non-icteric cases, and may, therefore, be regarded as an

expression of the general toxæmia; the probability is that the same holds good for the other types.

In none of the types I have especially described is hæmolysis an important factor. In those diseases in which hæmolysis *is* probably the main factor in the production of the jaundice, the jaundice is usually slight in degree and other symptoms predominate. The differentiation between a mainly hepatic and a mainly hæmolytic type can usually be arrived at on clinical grounds, but there are certain laboratory tests which may give additional information. The presence of anæmia suggests hæmolysis, and in suspected cases repeated hæmoglobin estimations should be made. In acholuric jaundice an increased fragility may be demonstrated by incubating the red cells with varying dilutions of saline. Recently Professor Van den Bergh, of Holland, has evolved a test which not only allows of the detection of bilirubin in serum before bile-staining can be seen in the skin or shown in the urine, but which also serves to distinguish between an ordinary or extra-hepatic obstructive and a toxic or hæmolytic type of icterus.

Briefly the test is performed as follows :—To 1 c.c. of serum is added ·25 c.c. of Ehrlich's Diazo Reagent; in an obstructive jaundice a bluish-violet colour almost immediately appears. In a toxic or hæmolytic jaundice the colour is only obtained after precipitating the albumen from the serum with 96 per cent. alcohol.

Doubtful or diphastic reactions are also obtained, and the clinical value of the test remains to be established.

A test for impaired hepatic efficiency has also been recently described which depends upon the fact that in health no appreciable rise in the blood sugar after the ingestion of 50 grms. of lævulose is demonstrable, but that in liver-disease a rise in the curve of blood sugar occurs which is in proportion to the amount of liver damage. The method has already been employed in estimating the degree of liver-inefficiency resulting from a toxic salvarsan hepatitis.

The treatment of all forms of toxic and infective jaundice includes complete rest, free administration of fluids, and a very low, mainly liquid diet. Strathy showed in the cases of salvarsan poisoning that the subjective symptoms and general condition definitely became worse if an attempt were made to increase the diet in the acute phase of the illness, and that the tolerance of food often returned very slowly. Skimmed milk, since fats are especially undesirable, and glucose were the chief element of the diet he advised. I found the spirochætal cases quite unable to take food, even as compared with other febrile cases of equal severity. Glucose and alkali should be freely given by mouth or rectum to counteract acidosis in the graver cases.

In the case of spirochætal jaundice, specific sera have been employed, and judging from the effect of the serum of human convalescents on infected guinea-pigs, encouraging results might be anticipated. I have not, however, seen any conclusive reports on the subject. The jaundice of relapsing fever, malaria and syphilis have their appropriate specific remedies. In all the chemical poisonings it goes without saying that exposure to the toxic substance must at once be discontinued and, from the prophylactic point of view, that a fair clinical estimate of hepatic and renal efficiency is desirable before any intentional exposure occurs.

Briefly to summarise again the differentiation between an extra-hepatic obstructive jaundice and the various forms of toxic jaundice one may say that clay-coloured stools in the former are the rule, while in the latter normal or bile-stained stools are common; in the more chronic cases of the former greenish and bronze shades of icterus may be seen, whereas in the latter it is always a yellow icterus; in the hepatic poisonings, hæmorrhages, nephritis and coma are common and in the former very rare; in those cases in which hæmolysis plays the main part the icterus is usually but slightly marked and other symptoms predominate, while in the hepatic intoxications the deepest shades of jaundice may be encountered; finally, radiograms of the liver, the lævulose test for hepatic efficiency, hæmoglobin estimations and blood films, and Van den Bergh's differential test for bilirubin in the serum may further help to establish a correct diagnosis, and in febrile cases bacteriological investigations and animal experiment may complete the picture.

Whatever experimental value these tests may have I need hardly point out to you that they are in the majority of cases of very slight importance, as compared with a careful clinical history and analysis of symptoms.

Presentation to Dr. and Mrs. Lauriston Shaw.

A very interesting ceremony took place on Friday, 23rd June, at the Connaught Rooms, when the past and present members of the London Panel Committee met at the luncheon table for the purpose of presenting Dr. and Mrs. Shaw with a Cabinet, a complete set of the Encyclopædia Britannica, and an Æolian Vocalian in recognition of Dr. Shaw's services to the Committee as Treasurer from 1913-1922.

There were present:—Dr. Cardale (the Chairman of the London Panel Committee) and Mrs. Cardale, Dr. and Mrs. Farman, Mr. and Mrs. T. B. Layton, Dr. and Mrs. Claude Taylor, Dr. B. A. Richmond (the late Secretary of the London Panel Committee), and many others.

DR. CARDALE:—Ladies and Gentleman,—Before I proceed to the remarks that I have to make I should like to say that we have had a number of letters expressing regret at inability to be present to-day. I do not intend to read them all to you, but I do wish to read one from Dr. Ethel Bentham, who has been associated with Dr. Shaw on the Panel Committee since its inception, if not before then. I think she was on the former Committee. The letter from Dr. Bentham reads:—

> "I am writing to tell you of my extreme regret that I am unable to support Dr. Cardale in expressing our great indebtedness to Dr. Shaw as a member of the Panel Committee from its beginning, and of the Provisional Committee which preceded it. No one knows much better than I of all we owe to the unfailing patience, foresight, and understanding which he brought to the guidance of our sometimes tangled and difficult affairs. Standing, as he does, a little apart from the actual struggle, he is able to see things from a different angle and to give us help and advice we should never have found for ourselves, while no other member of the profession in his position has thought of giving us this interest. I repeat my regret that I cannot be present. Nothing but the fact that the only possible holiday for me is the month of June, and the fact that I shall be out of England at the time makes me deny myself the pleasure of being present."

That letter very well expresses what I am here to express to-day, what we are all here present to express to-day, and that is to try and give expression in a very small degree to our feelings of gratitude to Dr. Lauriston Shaw for all that he has done for the panel profession, and I may say not only the panel profession, but for the medical profession at large during many years past.

I am not myself qualified to speak of Dr. Shaw's activity before the Insurance Act because at that time I was not meddling in medical politics. I was a quiet, harmless individual in those days who very seldom left his home fireside and I had not the advantage and the pleasure of Dr. Shaw's acquaintance, but we all do know what a very, very large and important part he took when the Act was framed. I think that a good deal of what was good in the Act we owe to his energies, to his foresight and to the influence that he was able to bring to bear upon others who were framing the Act.

Since the Act was passed Dr. Shaw's activities are well-known to all of us. He has, of course, been a member of the Panel Committee since its inception, he has been Treasurer of the Panel Committee and has done us yeoman service in that capacity. Dr. Shaw has always his eye on the way in which our funds are spent. He is always the one to restrain us if we are a little bit inclined to overstep the mark in the way of extravagance. I do not think that he brings that berserk view to bear on us which is perhaps exemplified in the present Geddes Acts. He has not been quite so violent as that, but he has always kept a watchful eye on the way in which our finances are conducted. I think it has not been so much in his position of Treasurer that he has been so valuable to us, but as a member of the Committee. His influence among us has always been a good one. I need hardly say that his advice, his counsel have always been accepted by us and listened to by us commensurate with their value.

He has also represented the Panel Committee on various other bodies, and not only represented the Panel Committee, but he has been placed on various other bodies, such as the Insurance Committee, by the Ministry of Health. The value of his services to us on that extremely difficult Committee are beyond all estimate. I think that his services have been of particular value in that he did not directly represent the Panel Committee on the London Insurance Committee, but was appointed thereto by the Minister of Health.

Now we all know what an extremely difficult thing it is to persuade any body of lay people with regard to medical matters, but I am quite sure that Dr. Shaw's sweet persuasiveness has done more for us on the Insurance Committee than half-a-dozen other men who are perhaps a little more violent in their methods.

Then I think I am right in saying that Dr. Shaw has represented us at the Annual Conference of Local Medical and Panel Committees since its inception. Always sure of a ready hearing, Dr. Shaw's presence there has been of inestimable value to the panel profession and to the practitioners at large, and we hope that we are going to see him represent

us there this year as he has so many years in the past. Ladies and Gentlemen, if I went on to give an entire and complete list of Dr. Shaw's various activities on our behalf we should be here till this evening, but I should just like to mention one other body on which Dr. Shaw represented us and that was on the old Advisory Committee of the Ministry of Health. I am quite sure he gave very valuable service in tendering advice to that body, and, as I think Dr. Ethel Bentham said in her letter—Dr. Shaw's advocacy for us has always been more valuable in that he is not himself a panel practitioner or a general practitioner, but is in a very distinguished position. I think that where the panel practitioner says "we ought to be treated in this way or our advice should be taken in this matter," it is often very naturally laid down as an interested statement and not much notice is taken of it, but when a very distinguished person of Dr. Shaw's standing puts these matters forward, then I think they attract a great deal more attention than when they come from ourselves and we are much more likely to get what we want.

I think I have mentioned a good number of Dr. Shaw's activities on our behalf, in fact he has always represented us on something somewhere, and I feel quite sure of this, that if any of us who are panel practitioners ever reach the Kingdom of Heaven, and if we are able to believe what some of our friends say, which seems extremely improbable, I am perfectly certain we shall find our friend Dr. Shaw there on some Committee or other looking after our interests as he has done here.

It has not only been for what Dr. Shaw has done for us that we have valued him, it is very very largely because of Dr. Shaw himself, because of his personality, and because of that influence for good that he has always brought to anything that he has touched. We have come to value him very highly indeed as a colleague, but we have also learnt to value him more highly as a friend, and Dr. Shaw's friendship has been exercised in many ways and we hope, I think everyone of us who has been on the Panel Committee, both present and past members—we all hope that he allows us to call him friend and not merely colleague.

Ladies and Gentlemen, I have something more to say a little later on when we are actually making our presentation to Dr. L. Shaw. As you have to hear me again then, I will conclude my remarks just now.

Dr. Claude Taylor:—Mr. Chairman, Dr. Lauriston Shaw and Mrs. Lauriston Shaw,—It must have rather appalled you to look on the programme and see anything so dreadful down as a speech. I assure you I am not responsible for having such a word put down on the programme and I do not propose to inflict a speech upon you, but merely to echo Dr. Cardale's sentiments, which are the sentiments of all of us, as regards the services that Dr. Lauriston Shaw has rendered to us.

I had the benefit of knowing him sometime previously to that when Dr. Cardale became acquainted with him, because I met him in his office, as Dean of the Medical School, when I entered Guy's; and from that time till now our friendship has been growing. It is not often we can say that a friendship continues and increases through so many years, even though there may not be always very many opportunities of meeting. Dr. Lauriston Shaw is that kind of man, the longer you know him the more you get to like him, and appreciate him. Coming to the time of the Insurance Acts he came forth, as the protagonist of those who were prepared to take up this national service and as a David, one might say, against the Goliath of opposition among the British Medical Association and the general feeling among the medical profession. Dr. Lauriston Shaw did some wonderful service and, with a few pebbles carefully inserted in the *B.M.J.* and in the Councils of the State, was able to slay the opposition and to a large extent, remedy the chief causes of opposition in the medical profession. I feel I would like to emphasise the particular point Dr. Cardale made as regards Dr. Shaw that he has had practically a unique position in our Panel Committee through being himself not concerned with panel practice. We have all been personally directly concerned with the working of the National Health Insurance Acts.

Dr. Shaw has had an entirely disinterested position; he has come with the object of helping those who were concerned and as Dr. Cardale has said, of helping the medical profession as a whole, and although he has been of inestimable help in the various difficulties we had to encounter as we went along, I always feel that the great debt that we owe to him has been that he has always been a man looking towards the future; that he has tried to see in what direction this work, this national work was likely to develop, and should develop. I have only been on a few of the Committees that Dr. Shaw has been on, but some of them have been with the idea of the schemes and principles without which this service could not proceed, and so gradually we have seen this enormous change in the attitude of the profession in this Country towards the National Health work.

I believe there is a proposition before the Annual Meeting in Glasgow to delete that old minute which I believe still exists, that it is derogatory to the profession to have anything to do with the National Insurance work. In those days those who were opposing its being put forward looked down upon those who began to take it up. We almost felt

ourselves to be those who eked out the precarious existence of dispensers with minimum fees.

A man of the prestige of Dr. Shaw coming in, and even allowing people to see him shaking hands with us, began to give us a little more self esteem, and other people found that after all there was something in this national work in which they would like to join, and now it is regarded as one of the established means of helping to improve the health of the people.

Dr. Shaw has, as I said, been of inestimable value. I was going to make a remark about some of the things that we are asking him to accept as a little memento of our association with him, but as Dr. Cardale has not altogether finished his speech, and alluded to those facts I won't do more than just mention this. One of the gifts we hope to give him is a copy of the Encyclopædia Britannica. I understand that that was his choice. I have always found in my own experience of Dr. Shaw, that there were two, as one might say, alternative encyclopædias to our own—say the Encyclopædia Britannica—well, perhaps you will see what I am referring to.

I will conclude by saying that although there may have been times when we have differed from him on matters of opinion, I do not think they have been often . He has had a wonderful way when we have been at loggerheads in Committees of being able to say a few words that have practically brought us to a unanimous decision and even if we have, a few of us, even continued to disagree with him, we have still continued to love him and I think that that is the feeling in our hearts to-day.

DR. CARDALE:—It is now my very pleasing duty to make the small presentation on behalf of past and present members of the Committee to Dr. and Mrs. Shaw. It was our desire that Mrs. Shaw should be associated with Dr. Shaw in this matter. I can only say how delighted we are to see Mrs. Shaw among us to-day. (Applause.)

I remember in one of Dr. Shaw's eloquent speeches, proposing the health of the ladies on one occasion, when Mrs. Shaw I think was not present—it was a very eloquent speech—Dr. Shaw impressed us with how much the medical man owed to his wife. Now I am quite sure when Dr. Shaw made that remark he was speaking from his own experience and that he had Mrs. Shaw in his mind. It is a very great pleasure indeed to us to associate Mrs. Shaw with Dr. Shaw in this presentation. Dr. Shaw has chosen for his presentation a cabinet which, among its other duties is intended to contain his agenda papers. I do not know whether he thinks that possibly the English of the Panel Committee's Agenda Papers is such that they had better be put out of view in a cabinet. I do not know whether that is what led him to choose that. I perhaps should not have said that as Dr. Farman has had to go and he is generally responsible for the English in our agenda papers. However, that may be, Dr. Shaw has chosen that for one thing. He has chosen the Encyclopædia Britannica, and he is going to add to his already immense store of knowledge a great deal more in the perusal of that extremely profound book. I expect probably that in the future when Dr. Shaw is making one of his excellent speeches on some very important matter such as the capitation fee of the panel practitioner, or something like that, that he will break off and say "I think it is not out of place at this point to mention to you the life history of the Ornithorynchus pallida" or something like that. I am quite sure that he will not be able to resist giving us a few of his researches into that book; and then lastly Dr. Shaw has selected a gramophone which we have had the pleasure of hearing earlier in our proceedings to-day. That I think will be a little lighter relaxation from his study of the encyclopædia.

Well, Ladies and Gentlemen, we are making Dr. Shaw this presentation not in any sense as an attempt to repay him for what he has done for us, for that is quite impossible, but we wish him, and Mrs. Shaw, to accept these things as a token of the very high esteem in which we hold him, and of the friendship which we extend towards him, and at the same time expressing the hope that both he and Mrs. Shaw may long be spared to enjoy these small gifts.

DR. SHAW:—Dr. Cardale, Dr. Claude Taylor, Ladies and Gentlem&en,—You are being so kind to me; you have been so kind to me, and I doubt not that you will continue to be so kind to me that I find it extremely difficult to find words to express all I should like to say, but I make the effort, and first I should like, if I may, to thank those of you who are here to-day, who have come here to-day with so much kindness, to add emphasis to the kindness you are already doing me, adding enormously to our pleasure in receiving this presentation—that we should have it presented to us surrounded by so many old and new friends. I know how extremely busy many of you are and if, at this time of the year, there may be a little more leisure, we regard it as extremely kind of you to sacrifice some of that leisure by coming here to-day.

Then I want to thank some people, I do not know who they are, but they are the members of the Sub-Committee who carried out the details of this presentation. Here I should like to make a confession. There is, I think, some sort of kink in my psychology which has always aroused some sort of opposition whenever I have heard that I was going to receive a present. I do not quite know why it is. I should almost like, if time permitted, to consult

some of you to-day, some of you general practitioners, as to the cause of this kink in my psychology, but I have not got a medical card upon me and I am not quite sure that you would recognise my title to benefit, nor, if you did am I quite sure that you would regard the investigation that would be necessary to discover my psycho-analysis or the examination of my blood antibodies, as falling within the category of those services which can, in the best interests of the patient be properly rendered by a general practitioner of ordinary competence and skill. (Applause.) (I really accept the applause because I believe that is the first time in any public meeting I have heard that sentence recited without the speaker breaking down. That is the result of having learnt it by heart.)

Really it is not necessary, because this Sub-Committe to whom I am now tendering my thanks, somehow or other straightened out the kink and at no moment after first hearing of this present has the slightest opposition been aroused. No negativism has been aroused in my spirit at all. I attribute it to three possibilities.

In the first place I received this intimation in a letter written by Dr. Farman. I would like to say how sorry I am to hear that Dr. Farman has had to go. I feel quite sure, in fact I know, that he has gone on some good errand. He has gone to protect some panel practitioner against a possible injustice; that is what he is always doing. I know of Dr. Farman's capacity for writing letters. He has written to some of you to say that you are suspected of excessive prescribing. I am quite sure when you receive these letters, so charmingly are they worded that you are at once desirous of confessing your sins and promising not to sin again. I received such a charming letter that any spirit of opposition was disarmed.

Then I have to thank the Sub-Committee because they gave me such a wide choice in the selection of the presents I might receive from them. You have been told what they were. I only just want to explain to Dr. Cardale that the object of that cabinet is not to contain the past agendas of the Panel Committee, but it is to contain the current agendas. When I come to any Sub-Committee or Panel Committee I frequently have to tell Miss Croucher that I have forgotten my agenda. It is the current agenda that I propose to put in that drawer, but I shall still I expect, come to the meeting without it and Miss Croucher will have to provide me with a surplus copy. The suggestion of this Sub-Committee which entirely disarmed me was that there should be associated with me in this presentation, my wife. That disarmed me entirely. I might tell you, never in our married life has my wife once said to me that it were better for our practical advancement if, instead of writing these memoranda on professional Unity or the Dignity of Trade Unionism, I had devoted myself to recording some of my very rare successes in diagnosis and treatment or even my failures. Never has my wife said that. Never has she, although she is an accountant, informed me of the enormous number of units of credit which were due to her, never prepared even a financial statement. If she were to deduct from the number of hours which I have spent with her at social functions such as this, at matinées or on the river! Nor has she said to me that we should have had a much more peaceful life at any rate if I had been content to accept the good gifts which the Gods have showered upon me in profusion and not worried myself as to whether other people were getting these good gifts too. Not only has she never protested, but she has given me always the utmost sympathy and support in all my work. I cannot help feeling that if I have been able to earn any credit in my public work it is in large measure due to the support I have received from my wife.

Now, Sir, I have come to the main theme and that is to thank the past and present members of the Panel Committee of London for their kindness in expressing their gratitude to me in such a generous manner. I cannot better tell you how much I feel this gratitude than by telling you that I believe the boot is entirely on the other leg. I am far more indebted to you than you can be indebted to me. I can never forget the time when I was, perhaps, one of the most unpopular persons in the profession when, owing to my disagreement with some of my colleagues I found nearly all the channels of my activity closed to me—political, educational, professional—but you at that time invited me—co-opted me upon the Panel Committee and put me in a very responsible position as your Treasurer. You, in fact, allowed me to continue to be, what at that moment I am very grateful to say Dr. Cardale began to be, a medical politician.

Here I should like to say every man here is a politician. I should like to say that I entirely disagree with the attitude which is at present taken that medical politics are no sort of politics or derogatory and that there is something less valuable in medico-political work than in other forms of medical work. If I should place the usefulness of our work as medical men I would put first, of course, discovery, research. Here I should like to say that I believe it is possible for all of us to render some service in that direction. The activity that seeks out and finds new causes of diseases and methods of treatment and renders the whole of the community its debtor. Next I put our medico-political work that enables these researches to be made available for the whole community, and I would put last of all those men who are restricting their energies in a way they ought not to restrict them. Last of all is

the duty of supplying these benefits to individual patients. Those men who are devoting themselves entirely to that, and cast stones at us because we engage in medico-political work, are making a great mistake. They are missing a great opportunity and are making a statement which is entirely untrue.

Not only have you given me an opportunity of engaging with you in medico-political work, but I am indebted to you for giving me an opportunity of taking part in what Mr. Harris of the Ministry of Health called "the great experiment." It has given me the greatest pleasure because this experiment embodies two great principles which I have held from my earliest days. One of them I became convinced of when I was still a lad in my teens helping my father, a general practitioner, to make up his accounts and send out his bills. The conclusion I came to then is that it is absolutely impossible for the vast majority of people in this country to give adequate remuneration for the invaluable services of their medical practitioner in times of severe illness without some assistance in the direction of insurance. Our patients cannot pay our fees, except a very small proportion of them.

The second great principle, which did not come to me quite so soon, but came the moment I tried to enter into consulting practice, was that no system of medical service can be successful unless it is based firmly on the principle that the general practitioner is to be the first line of defence, and that additional services in the way of consultations or specialisms must be added on to, and in co-operation with that service, but not substituted for it. These two great principles, the guiding principles of my medico-political life, I found enthroned in this Insurance Act. It is because they are there it has been a great interest to me to take part in their development, to endeavour to see that whatever development takes place, these two principles shall not be spoilt, that I am so much indebted to you for giving me this opportunity. This experiment is a greater one than that. We are engaged in an experiment in settling in the future the problem of the relation between employer and employed and producer and consumer.

For these reasons I am entirely in your debt. Another reason why I am in your debt—in these last 10 years you have given me an opportunity of working with you. I have enjoyed working with you. When I contrast the ridiculous and libellous picture which has been drawn upon the stage and in papers of the panel practitioner as he is supposed to be by some of his enemies, and the panel practitioner as I have seen, known and worked with him in all these Committees, it makes me almost too angry for words. The joy it has been to me to work with men whom I have seen round the table, devoting themselves wholeheartedly to improving the position of their insured persons. I know that all their activities are with the firm determination of maintaining the high position of the profession, for it is only by maintaining the high position of the profession that our patients can be properly treated. I have had the pleasure of working with a body of men holding that position. I say I am indeed indebted to you for allowing me to do this, for allowing me to grow in their friendship. I have enjoyed the work immensely.

I shall remember to the last day this presentation you have made me and I shall remember still more the 10 years of happy work I have had, and the pleasant memories of the Panel Committee. Thank you very much.

MRS. SHAW:—Ladies and Gentlemen,—At this late hour you won't want to hear lengthy remarks from me. Indeed I feel it would be extremely presumptuous for me to address any lengthy remarks to such an august assembly as this. I am very glad of the opportunity of adding my thanks to those that have already been expressed by my husband for these most generous and beautiful gifts that you have given us. I can assure you that they will often be used and every time we use them we will be able to think of the kind friends who gave them to us. My husband has referred to the drawer for keeping his agenda papers in, and I may say that he will not appreciate that drawer more than I shall. If you could see the condition of his writing table at times I am sure you would sympathise very much with me and feel how greatly I shall appreciate this drawer. I shall now insist that all the agenda papers be promptly placed there. As for the gramophone, we are all very fond of music and as we do not live in London now and cannot often have it at first hand, it will enable us to hear the things that we like at home, and also give pleasure to our friends. I hope that amongst others I may look forward to have the pleasure of welcoming some of you on some not very distant occasion. I can only very heartily thank you from the bottom of my heart. We have been enormously touched by this very kind expression from the Panel Committee and I am very pleased to have an opportunity of meeting in the flesh some of the members of the Panel Committee, some of whom I have known for many years by name.

A vote of thanks was passed to those ladies and gentlemen who contributed to the musical programme.

The healths of Dr. and Mrs. Shaw and Dr. Cardale were drunk with musical honours.

Appointments.

Civil.

J. Allan Berry, M.S., F.R.C.S.E., Medical Superintendent, Napier Hospital, Napier, New Zealand.

The Guy's Hospital Ladies' Association Garden Fete.

The Garden Fête was held, by the members of the Guy's Hospital Ladies' Association, on Thursday, June 29th, and in spite of the weather being rather cold and showery, it proved a great success.

The Fête was opened by Viscountess Goschen at 3 o'clock, immediately after the Annual Business Meeting of the Ladies' Association. The number of visitors was estimated at about 3,000. The Central Band of the Royal Air Force played during the afternoon and evening and the Wards and Hospital Departments generally were thrown open and visited by a large number of people.

There were Stalls for the sale of Childrens' Clothing, Dolls and Fancy Articles, Flowers and other Garden Requisites, Cakes, Sweets and Baskets, Provisions of all kinds with a large number of Eggs, Garden Produce (worthy of Covent Garden at its best), Household Articles, including a blue Persian Kitten and a Hover Vacuum Cleaner, a Second-hand Stall for Books, China, Glass and Gramophone Records. These Stalls were continuously surrounded by eager buyers somewhat suggestive of the "Summer Sales." The "Bargains" soon went, and by 9 o'clock practically all the stalls were sold out.

There were also some very attractive raffles, particularly a most fascinating dolls' house and a small live pig. All the contributions to the stalls were sent by the members of the Ladies' Association and other generous friends of the Hospital.

The tent for ices and strawberries and cream was very popular and ices were still in large demand at 9 p.m., when the tent had to be peremptorily closed. The fruit salad tent also had a very busy time.

Tea was provided in the Nurses' Dining Hall, and the Massage Department; this was most admirably organised by the Nursing Staff, and both tea rooms were extremely well patronised. The Concerts arranged by the Nurses, during tea, were very delightful.

The "Side Shows" were an enormous success. The "London Cumanseum" attracted over 1,000 visitors, the Coco-nut Shy was very popular and very profitable, while the various other excellent and amusing shows in the Massage Department, and the Park were a source of much fun and enjoyment to crowds of visitors.

Dancing in the Nurses' Sitting Room proved a very great attraction, especially in the evening, when the capacity of the room was tested to its utmost.

Thanks to the loyal co-operation of all Guy's friends the Fête was a big success and though the accounts are not yet complete it is known that over £1,800 has been realised.

Reviews.

Synopsis of Midwifery. By Aleck. W. Bourne, B.A., M.B., B.Ch., F.R.C.S. Second Edition. (Messrs. John Wright & Sons, Ltd., Bristol.)

The second edition of this book differs very little from the first edition. The chapters dealing with the Toxæmias of Pregnancy, and the Hæmorrhages of Pregnancy and Labour, have been described more fully, particular attention being paid to treatment.

The author is to be congratulated upon writing such a clear, concise, and simple book containing all the important details of midwifery, suitable for use as a supplement to the larger text books.

This book is primarily intended for students who are revising their work for the final examination, and as such it should be of great value.

Cricket.

GUY'S v. DOWNING COLLEGE.

Played at Cambridge on Wednesday, June 7th.

Atkinson, fast medium, and Fulljames, a slow left hander, started bowling against us, Wooldridge having won the toss as usual. Shaw was out in the first over, caught slips, and Helder batted well for a short time. We had 3 for 26 and 4 for 70, not a very brilliant start. Although he gave two chances, Wooldridge played quite soundly, and gave us the necessary fillip; he was out to an easy catch at mid-on. Van Schalkwijk and Droomer both made runs, Droomer particularly hitting them all over the place, usually round to leg. Hewetson hit one really hard; it just succeeded in falling out of the ground. Wooldridge and Droomer added 90 for the sixth wicket.

Our opponents' fielding deserves praise; it was excellent. Everybody seemed to pick the ball up cleanly and return a good length; it was all done keenly, too. An example for us, for we could do with improvement here. A mediocre bowling side with a few average bats, not brilliant, would get on well if its fielding were good, and there is no excuse for bad fielding, dropped catches or other such exhibition. It would be more interesting now, perhaps, to return to the other half of the game!

We started most encouragingly, dismissing both Timms and Atkinson for practically nothing, and having got 7 wickets for 78 the game looked like ours. *But Jenkins, who had been in for some time,* though not scoring much, continued to stay in. He found a good partner in Wallington and together they piled up the runs; both made certain of scoring off loose balls, and they played carefully throughout. They added 117 for the eighth wicket—a wonderful performance when all seemed lost. We were still 18 runs ahead when Wallington got out; 2 runs more

and May was bowled—great excitement. There were now eight minutes to go, and 17 runs for them to get to win with the last man in. 9 runs were added in Shaw's over. There were two singles scored off the first two balls of Van Schalkwijk's over, then a leg-bye. Jenkins then hit a 4 and we were equal. There would have been an easy catch the next ball had Ensor been closer in, but as he was not there was no catch but a short run. Having recovered so wonderfully they deserved to win. Our fielding was particularly good; Woldridge and Van Schalkwijk both bowled well, and Crisp kept wicket quite well

Guy's.

G. D. Shaw, c Fowler b Atkinson	2
C. Arkles, c Heys b Fulljames	6
L. B. Helder, b Atkinson	17
A. G. Ensor, c Atkinson b Pilling	6
T. Wcoldridge, c Fowler b Wallington ...	94
J. G. Van Schalkwijk, c Pilling b Timms ...	16
P. Droomer, b Atkinson	31
J. D. S. Thomas, b Wallington	5
J. C. Hewetson, b Fulljames	16
E. J. Crisp, run out	0
C. G. Bowen, not out	6
Extras	14
Total	213

Downing College.

W. W. Timms, b Van Schalkwijk	10
C. W. R. Hodges, b Wooldridge	6
G. F. Pilling, b Wooldridge	14
B. G. B. Atkinson, c Shaw b Van Schalkwijk	7
C. Jenkins, not out	88
R. Fulljames, c Shaw b Woldridge	16
H. L. Heys, c & b Wooldridge	2
J. F. Steedman, lbw b Wooldridge	6
H. G. Wallington, b Van Schalkwijk	51
R. May, b Shaw	0
L. J. Fowler, not out	7
Extras	7
Total (for 9 wickets)	214

Bowling.—Van Schalkwijk, 3 for 77; Wooldridge, 5 for 46; Shaw, 1 for 35; Arkles, 0 for 28; Ensor, 0 for 8; Bowen, 0 for 7.

Guy's Hospital Hockey Club.

The Annual General Hockey Club Meeting was held in the Physiological Theatre, on May 26th, the President (Mr. Steward) being in the chair.

It was much regretted by all present that the Club was without a ground for the coming season, and all were constrained to make every endeavour to do their best to obtain one. The attention of the members of the Club was drawn to the Hockey Association's appeal on behalf of the Lord Roberts' Memorial Workshops, for a subscription of one shilling from every member of the Hockey Club. (The Hon. Sec. will be pleased to receive subscriptions from those members who have not already subscribed.)

It was also regretted that the appeal to the other hospitals for the institution of a "Second Eleven Cup," has, with the exception of St. Thomas's, met with no response.

The following Officers were elected:—

President—Mr. Steward.

Vice-Presidents—Mr. Fagge, Mr. E. C. Hughes, Mr. Ormond, Mr. Bromley.

Captain—W. S. Hunt.

Vice-Captain—C. G. Bowen.

Hon. Sec. and Treasurer—I. P. Spurrell.

Committee—F. E. Graham-Bonnalie, L. E. Owen, J. W. Schollum, G. Gathergood, R. Grant.

Last Season the First Team played 18, won 10, lost 4, drew 4.

Shooting.

The Hospital Rifle Club held their Annual Meeting in conjunction with the United Hospitals' Rifle Meeting, at Bisley, on Wednesday, 28th June.

So far as the United Hospitals' Meeting was concerned we were soundly beaten and Mr. Thompson, our President, is to be congratulated on the fact that this season he has been unable to attend during the Wednesday afternoon shoots for he has been spared from seeing the Armitage Cup slowly, but surely, lost to us, such a loss being coupled by the sweeping victory of Bart.'s at Bisley in nearly all the United Hospital events. J. Elgood, shooting strongly, with a score of 101, losing 4 points only. One cannot but acknowledge the very definite and strenuous efforts they have made to ensure their success, most of them spending their weekends during the season at the ranges and obviously such practice and training must give an advantage over those unable to devote so much time and not a little money to their shooting. Their team average for the last shoot of the series was 92 per man!

In the Inter-Hospital events, J. R. Moore shot well, all the favourites fashionably failing. A good field of eighteen turned out and let it be established at once that if enthusiasm has not run to weekends, it was displayed by the Hospital field, which easily led in numbers any other hospital.

Results—

Armitage Cup.—Bart.'s 1st, Guy's 2nd, London 3rd, St. Thomas's 4th.

United Hospitals' Events—

200 Yards Deliberate.—Elgood (Bart.'s).

500 Yards Deliberate.—Moore (Guy's).

600 Yards Deliberate.—Harker (Bart.'s).

1000 Yards Deliberate.—Harker (Bart.'s).

Snap and Rapid.—Harker (Bart.'s).

Grand Aggregate.—1st Elgood (Bart.'s); 2nd Irving (London).

Guy's Events—

200 Yards Deliberate.—Foy 1st, Moore 2nd.

500 Yards Deliberate.—Moore 1st, Bingay 2nd.

600 Yards Deliberate.—Hallpike 1st, Hamman 2nd.

1000 Yards Deliberate.—Taylor 1st, Beamish 2nd.

Snap and Rapid.—Hallpike 1st, Hart 2nd.

Newton-Pitt Cup for highest actual score at 200, 500 and 600 yards.—J. R. A. Moore.

Grand Aggregate.—1st Kingsbury (received 16), 2nd Lloyd (received 5).

The day was very showery, but none the less enjoyable.

Swimming.

WATER POLO.

The 1922 Team, after many experiments, settled down into quite a powerful combination, and succeeded in winning both the University and Inter-Hospital Cups; the former for the third year in succession, the Cup thus becoming our permanent property. There was, at the commencement of the season, some difficulty about the centre-back position, but, finally, C. A. Wakeford has filled it brilliantly, feeding his forwards well, without neglecting his vis-à-vis. P. G. Harvey and J. A. Simons have been consistently safe as backs; while F. A. Sampson, although he has had little to do, has started many movements by his accurate throwing-out. F. G. Hutchinson and G. Cohen have had ample scope for their excellent shooting; and the strength of the forward line has been further increased by L. Brown.

In the five cup matches played during the season, 36 goals were scored for the team, 2 only against.

Cup-Tie Team.—F. A. Sampson, P. G. Harvey, J. A. Simons, C. A. Wakeford, G. Cohen, F. G. Hutchinson, L. Brown.

University of London Water Polo Cup.

First Round.—Guy's v. Birkbeck College (scr.) walk-over.

Second Round.—Guy's v. Goldsmith's College, at New Cross. Guy's won 9—0.

Final.—Guy's v. East London College, at U.L. Gala, New Cross. Guy's won 7—0.

Inter-Hospital Water Polo Cup.

First Round.—Guy's v. St. Bart.'s, at Fitzroy Baths, 10th June. Won 7—1.

Second Round.—Guy's v. St. Thomas's, at St. George's Baths, 14th June. Won 8—0.

Final.—Guy's v. King's College Hospital, at the Bath Club, 28th June. Won 7—1. Scorers Brown 3, Hutchinson 2, Cohen 2.

GUY'S v. FOREST S.C.

At Fitzoy Baths, on 15th June.

Water Polo.—Guy's 2, Forest S.C. 2. Scorers for Guy's—Brown 1, Cohen 1.

Team Race.—Guy's lost by a touch.

Guy's Team.—Schofield, Marsh, Tucker, Dingle.

GUY'S v. GRAFTON S.C.

At Pitfield Street, 16th June.

Water Polo.—Guy's won 8—0. Scorers for Guy's—Hutchinson 5, Brown 2, Cohen 1.

Team Race.—Guy's lost by a touch.

GUY'S v. OLD PAULINES.

At St. Paul's School, 17th June.

Water Polo.—Guy's 1, Old Paulines 1. Brown scored for Guy's.

The Team Race and Swimming were lost badly, to superior swimmers.

In the Water Polo Match three minutes each way were played owing to the coldness of the water.

A. R. Marsh lost the diving by one point. Richards swam well in the Team Race.

GUY'S v. OLD BLUES.

At Pitfield Street, 30th June.

Water Polo.—Guy's won 4—2. Scorers for Guy's—Brown 3, Kempster 1.

Team Race.—1st String—Simons, Dingle, Wakeford, Kempster.—Lost by a touch.

2nd String—Cohen, Holloway, Hine, Sampson, Brown.—Lost.

SWIMMING AND DIVING.

The Swimming Team won the Inter-Hospital Cup with ease, beating the London Hospital by 30 points to 15 points. In the University Cup, however, they were disqualified as one of their men left his mark a fraction of a second too soon.

The United Hospitals Gala, held, by courtesy of the Committee, at the Bath Club, Berkeley Street, was an unqualified success. The galleries were filled, and the sides of the bath held their full complement of spectators. Members of the A.D.A. kindly gave an interesting display of diving; the Bath Club ladies gave an exhibition of various strokes; while Messrs. Griffiths and Wilkinson, of the S.C.A.S.A., were their inimitable selves.

The London Hospital won the 100 yards, while Guy's won the remaining Inter-Hospital events. H. Richards swam exceedingly well in the 100 yards—a distance at which he has only recently started practising. The Diving Cup was won by the London Hospital, by 7 points to 3 points.

The Guy's Nurses carried all before them in the Inter-Hospital Nurses Swimming Cup, winning it by 17 pts. to 8 pts. Special mention must be made of Nurse Garland, who won the 50 yards in a most convincing manner, with a very free and graceful stroke.

Lady Fripp kindly presented the Cups, Medals, and Prizes.

Our heartiest thanks are due to the Committee of the Bath Club for their great kindness, and to Mr. Wilson Taylor for his help.

Results—

Inter-Hospital Diving Cup.—1. Wilson (London), 2. Marsh (Guy's), 3. Barker (London). Won by London Hospital—7 points to 3 points.

Inter-Hospital 1 Length Race.—1. Tucker (Guy's), 2. Bekker (Guy's), 3. Fenton (London).

Inter-Hospital 100 Yards Race.—1. Wilson (London), 2. Richards (Guy's), 3. Theis (Guy's).

Inter-Hospital 50 Yards Race.—1. Hutchinson (Guy's), 2. Dingle (Guy's), 3. Bailey (London).

Inter-Hospital Team Race.—Guy's Team.—R. Schofield (Capt.), F. Bekker, F. R. Dingle, F. G. Hutchinson, A. R. Marsh, F. C. Tucker. Won by Guy's.

Guy's 30 points, London 15 points.

Notices.

RUGBY FOOTBALL CLUB GENERAL MEETING.

The Annual General Meeting of the Rugby Football Club will be held on Tuesday, July 11th, at 4.15 p.m., in the Physiological Theatre. It is most desirable that all, who intend to take an active interest during the coming season, should be present to elect the officials for the ensuing year.

In accordance with Rule (10a), Mr. P. K. Albertijn has been nominated Captain, Mr. F. W. Bekker Vice-Captain, and Mr. S. P. Meacock, Hon. Sec.

Photographs.—Those who ordered copies are asked to obtain them from any of the team Secretaries as soon as possible.

The post cards of the First XV. can now be obtained from the Hon. Sec.

Garden Fete.

The following letter has been received by Mr. Edney:—

Dear Mr. Edney,—I am desired by the Committee of the Guy's Hospital Ladies' Association to express our gratitude to you and the Students of Guy's for the amount of trouble you took to make our Fête a success and for your great assistance on the day.

The Ladies' Committee appreciate that, without your help we could not have achieved the excellent result. We took in cash some £1,800, and in addition our joint efforts have succeeded in popularising Guy's Hospital among a large number who have had no opportunity before of visiting it.—Yours faithfully,

MABEL BONSOR.

The Golf Club.

At the Annual Meeting held on June 27th and July 5th, Dr. Cameron being in the chair. The following resolutions were made:—

1. That the General Annual Meeting take place in October. The next meeting to be held in 1923.
2. That there be a Committee Meeting at least once a month.
3. That the Handicapping Committee consist of five members, three to form a quorum.

The following Officers were elected:—

President—Dr. H. C. Cameron (re-elected).

Vice-Presidents—Mr. L. Bromley, Mr. C. H. Fagge, Dr. J. Fawcett, Mr. M. F. Hopson, Mr. E. C. Hughes, Mr. H. C. Malleson, Mr. A. W. Ormond, Mr. F. J. Steward (all re-elected).

Captain—L. W. Cann.

Hon. Sec. and Treasurer—F. E. Graham-Bonnalie.

Hon. Treasurer—F. W. Schofield.

Committee—J. P. Evans, K. Hooper, F. James, H. Moore.

Handicapping Committee—L. W. Cann, F. W. Gathergood, F. E. Graham-Bonnalie, K. Hooper, H. Moore.

In the first round of the Inter-Hospital Cup Charing Cross scratched to Guy's.

Specialities.

THE PROGRESS STUDIES' 37, Borough High Street, S.E.1. Messrs. A. & P. Greenberg.

Those interested in Photography will find the services of the Progress Studios very convenient.

Situated close to the Hospital, they have every facility for developing and printing at most moderate prices, and are always available for taking outdoor groups.

Births.

COCKS.—On Easter Day, April 16th, 1922, at Knapdale, Brown's Town, St. Ann, Jamaica, the wife of Gilbert Anderson Cocks (née G. M. Shaw Allen), of a son—Peter.

MARSH.—On June 9th, 1922, at 1, Cantelupe Road, Bexhill-on-Sea, the wife of H. E. Marsh, M.C., L.D.S.Eng., D.D.S.Penn., a son.

Death.

MAGILL.—On June 5th, 1922, at Hawera, New Zealand, Christine, wife of Dr. A. G. Magill, and third daughter of the late Henry Snelling, Esq., and Mrs. Snelling, Sidcup.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE have received for review a copy of the Hospital Financial Report for 1921. In spite of the efforts which have been made, we are still faced with the substantial deficiency of £23,079 18s. 8d. Strenuous efforts are being made to cope with this deficiency, which is due, not to a decrease in income, but to the increased cost of maintenance. But in spite of rigorous economy in various ways, and some reductions in the cost of supplies, Ordinary Expenditure stills remains at practically the same level as last year—£163,000—a fact which tends to show that the cost of maintenance is not likely to come down as time goes on.

The Treasurer, Lord Goschen, in his report for 1921, draws attention to the fact that although the funds obtained by the various collections organised by the Hospitals Appeal Committee will bring great relief to the Hospitals in helping to lift the burden of accumulated debt, nevertheless "there will still be a gap between Expenditure and Income which can only be filled by a steady flow of public benevolence if the Voluntary system of Hospital management is to survive."

The practice of appealing to In-Patients for contributions towards the cost of their maintenance, has been in force for some months.

This appeal points out that the income which the Hospital derives from its endowments provides about one-third of the total cost of each In-Patient per week, and that the remainder must be collected from grants, voluntary subscriptions and contributions from patients. (The cost of each In-Patient per week in 1921 was £4 6s. 1d. It is obvious that not many In-Patients can afford to pay for their maintenance. Nevertheless, the last of the three sources of income named above has produced about £6,000 for the Hospital funds.)

In passing, it is pleasing to read in the Report that the nurses' hours of duty have been reduced. This reform follows the establishment of an improved scale of salaries reported last year. Nurses throughout the United Kingdom have been for years notoriously underpaid and overworked, and any reform in this direction is to be welcomed.

Much of the expenditure during 1921 has been due to the necessity for extensions to the Central Station, with the installation of an additional steam boiler, engine, dynamo, and pumps, the Hospital having outgrown the old plant. These changes are now in progress.

The opening of the new block provides a well-equipped department for Massage, Remedial Exercises, and Electrical Treatment, while the upper floors enable 60 additional bedrooms to be provided for the nursing staff.

As everyone knows, new Anatomical and Biological Departments are in course of construction. The total cost to the School will amount to £45,000; this sum is being borrowed by the School and the interest will be a heavy charge on the School funds for many years to come.

With the provision of new Departments for treatment, and others for educational purposes, the Hospital will be brought thoroughly up-to-date, and adequate arrangements will be made for coping with new requirements. But it is to be remembered that all these cost money, and we hope to see, in the Report for 1922, a considerable reduction in expenditure, and in that recurring deficit which annually crops up, well over the £20,000 mark.

We offer our sincere congratulations to Dr. J. G. Porter-Phillips, who was made a Fellow of the Royal College of Physicians at the last Comitia.

We are sorry to learn that Mr. J. Joffe will shortly be leaving the Hospital, in order to return to South Africa. Those who have had the privilege of working under him, or of accompanying him on his rounds in the surgical wards will feel a very real regret at his departure.

His friends will have an opportunity of giving expression to their regard for him, before he goes. A farewell dinner will be held at Oddenino's Restaurant, on Thursday, July 27th. Any Guy's men who have not yet obtained tickets, and desire to do so, are requested to communicate with Dr. G. B. Dowling, or Mr. D. J. P. O'Meara, not later than Monday night, July 24th.

We publish, in this issue, an account of the doings of our various Rugby Teams, during the season 1921—22. As regards the First XV., a third very successful year, under Doherty's captaincy, is recorded. Doherty has done a great deal for Rugby Football at Guy's, and it must be satisfactory for him to be able to look back upon such a successful record for three years. As will be seen in the account of the General Meeting, P. K. Albertijn will captain the side during the 1922—23, which holds forth every prospect of being as successful as the last.

We cull the following from the pages of *St. Mary's Hospital Gazette*, "The desperate attempt to check the rapid increase in the number of surgeons continues. Of 169 who recently confronted the Examiners in the Primary Fellowship, only 46 were approved. It is but a momentary set-back. The time is coming when few towns will be without a Fellow of the College practising in their midst. . . . Pleasant to note among the victors the name of W. D. Doherty, the Guy's Rugger captain of the past three years."

We have received a copy of a pamphlet written by Dr. F. Truby King, Director of Child Welfare for New Zealand, and issued by the New Zealand Department of Health. This pamphlet deals with all matters appertaining to the care of a baby during his first month, and also pays no little attention to the care of an expectant mother. Couched in simple, intelligible terms, it is likely to appeal to the average reader. In New Zealand this pamphlet is

issued by Registrars with the marriage license, it may be had from the Plunket Nurses, a Society of Nurses especially trained in the care of children, and it was issued to every married woman over a certain age at the last census.

The Health Campaign inaugurated by Dr. Truby King is based upon a recognition of the fact that a healthy infant usually means a healthy adult. The future generation in New Zealand is being guarded from disease by a great system of education of mothers in the care of their children. The mother is taught how to live, diet, exercise, and rest during pregnancy, important facts as to the relative value of breast-feeding and artificial feeding are widely disseminated, and generally the whole nature of the infant welfare work is such as to make New Zealand a model in this respect to other civilised nations.

It is pleasant to reflect that an old Guy's Sister, Miss Paterson, is associated with Dr. King in his work.

For the first time since its re-establishment, the rule that the number of senior dressers on each firm shall be limited to six has been definitely enforced, with the result that a certain number of men have been obliged to remain junior dressers during their third surgical appointment. There is no doubt that this rule entails considerable hardship for the rejected ones, and that with oncoming entries into the wards continuing at their present rate, there is every likelihood of the evil of congestion having a cumulative effect. If half the dressers who fail to secure the senior appointment this time, apply the next time, they will add to the difficulties of the oncoming dressers. This problem is likely to solve itself in time with the return to normal of the annual number of entries.

The reasons for limiting the number of dressers have already been adequately explained, and it has been shown that the value of a senior dressership, in reality a sort of extra appointment, an honour, would be considerably reduced by the admission of a larger number of dressers.

At the same time, while admitting that this limitation is necessary, a certain number of students (not those who have failed to secure appointments) feel that the methods of selection of dressers are in some cases rather obscure, one or two of the best men being passed over for reasons, which are not at first sight apparent.

Obviously the best, if inadequate, means of judging as to a student's capability, in the absence of personal knowledge, is to be found in the system of "sign-ups." If a student's record is good, we presume that he will succeed. If he has a succession of A 5's it is to be assumed that he will get appointments, other things being equal. We feel that it would be a great improvement if students were allowed to inspect their *dossiers*. An officer in the Army is usually made aware of a C.O.'s adverse report as to his capabilities. Why should secrecy be maintained at the Medical School Office? One who is permitted to inspect his card, may find out, in the event of failure, where he has erred, and in this way a very real sense of injustice may be removed.

Correction.

We regret that an error was allowed to creep into the article on "Injury to Epiphysis of the Ulna," which appeared on p. 283 of our last issue.

In the paragraph beginning "Ruth —., aged 13½," the words "skiagrams I. and II." (referring to the inset) should read, "skiagrams III. and IV." In the paragraph below, "plates III. and IV." should read "plates I. and II."

"The Risk."

Produced at the Strand Theatre, July 5th, 1922.

By a generous act on the part of Mr. Arthur Bourchier and those responsible for the production of this new play the proceeds of one of the earlier performances are to be devoted to Guy's Hospital. It is by no means the first occasion on which Mr. Bourchier has shown himself a good friend of Guy's by exercising his great art on the Hospital's behalf. On this occasion it is perhaps especially appropriate that a great surgical hospital should benefit. "The Risk" is a slashing attack on unscrupulous surgery and shows us the surgeon quite at his worst. The Hospital Benefit Performance is perhaps a graceful recognition on the part of the management that there are surgeons and surgery of another and better sort.

"The Risk" is an adaptation by Mr. José G. Levy of the play "Le Caducée," by André Pascal, produced at the Renaissance in Paris last year. André Pascal, it may be added, is the pseudonym of Baron Henri de Rothschild, who is himself a member of the medical profession.

Dr. Armand Revard and his sister Fernande are a pair of climbers. She has chosen the stage as her ladder, he the operating theatre. Probably he too was meant for the ordinary theatre, as he is a born *voyeur*. By the chance of a street accident he meets with Leroux, a shady financier, who by way of investment sets him up as a fashionable surgeon in the best quarter of Paris. His consulting-room is furnished with sham antiques to be palmed off on unsuspecting patients as another part of the unholy bargain. There he attains a great vogue as an exciser of innocuous appendices, a skilful performer of unnecessary laparotomies. Wealthy *malades imaginaires* gain comfort from his plausible tongue if not from his unscrupulous scalpel. Ladies especially find his bedside manner most grateful and comforting. Among them, a certain Comtesse d'Orsant consoles herself for an absent husband by losing her heart to him. She is useful also in introducing patients. The rich *Américaine,* Jessie Watson has all sorts of unpleasant symptoms due to the high living and late nights of a Paris season. She has been to see Professor Godefroy, a surgeon of the old school, who tells her the truth, that there is nothing wrong with her. Revard, when she comes to see him, is much more considerate. He tests her pupil reflexes and knee jerks, and is ready with a diagnosis in high-sounding terms that mean nothing. Treatment? Godefroy has said that none is necessary. "He is rather an old-fashioned surgeon, dear lady, and is probably not aware of the methods that modern science has given us." Clearly a course of expensive light baths is indicated—red and violet alternating, the violet especially is such an attractive colour!

Jessie Watson, who also has an absent husband (in America), falls in love with the fascinating surgeon, and in return he pockets her dollars, or such as can be spared from paying off the rapacious Leroux, who has other schemes afoot, and begins to be insistent, even nasty, about the return of his money, demanding payment within a few days. Practice as a surgical charlatan, although profitable, we begin to see has its drawbacks. When the absent husband in America sends an imperative cablegram demanding his wife's return, it is clear that so profitable a patient cannot be allowed to escape. She is the only means at the moment of raising the wind. The amorous Comtesse, who now realises that the American girl is her rival in love, has a plan. Jessie Watson must leave her mother, the Marquise d'Avranches, and stay with her at St. Cloud, close to Revard's private nursing home, to continue her "treatment." There she may easily be induced to undergo a costly operation. Revard after some hesitation, for he has faint glimmerings of decency, agrees to the plan.

In Act III., at Revard's nursing home at St. Cloud, the stage is set for the coming of Nemesis, in the person of Jessie Watson, now recovering, we are given to understand, from her operation. We see Revard as the born showman, inviting a crowd of fashionable Society folk to watch him in his operating theatre, having them photographed in theatre overalls; giving interviews to the Press; being a dichotomist i.e., sharing fees with the doctors who send him patients. He has found a new source of profit. His old friend and teacher the honest guileless old scientist Charrier, has discovered a new serum. The old fellow has taken up his quarters at the nursing home to complete his work on the serum. Leroux has already sold the discovery to a firm of manufacturing chemists and the contract, which may bring wealth to Leroux and Revard and a small percentage to the discoverer, only awaits Charrier's signature. This Revard readily obtains in one of the few spare moments that the exigencies of running a quack nursing home leave him. So busy is he that he keeps putting off his assistant and the nurses, when they tell him that a certain patient, No. 23, is not going on as she should, is not making the uninterrupted recovery that presumably should be the rule after operation in a quack nursing home, is in fact dangerously ill. Hæmorrhage from a slipped ligature is hinted at. No. 23, of course, is Jessie Watson, but Revard had

forgotten. Her parents arrive in a frenzy of anxiety, having only just heard of her operation. They suspect that all is not as it should be, they will get another opinion. Revard tries to mollify them with smooth words, professes indignation at the idea of another surgeon being brought in. It is a slight complication only, that he can set right by operation. On this plea he gets rid of the agitated father, and prepares for the theatre. While washing up, he has an angry scene with his assistant who is now thoroughly "fed-up" with the doings of his Chief and has decided to resign as soon as this particular case has been dealt with. They have just donned their rubber gloves when the nurse enters with the ominous news: "Number 23 is dead!" This effective "curtain" closes Act III.

Revard realises that his bubble reputation is at last pricked. Professor Godefroy arrives with some plain speaking about a criminal prosecution. The assistant leaves. The wretched man is left to his own thoughts and his eye lights on old Charrier's two flasks, containing the toxin and the serum. Old Charrier wanted a final crucial test on a human subject, and lamented that he could not try it on a condemned man. Revard sees in himself a fit subject for experiment, and injects 5 c.c. into his arm, notes down his symptoms and the time of their appearance. Even here he has no science, and spoils the value of the experiment by smashing the flask of antitoxin, the only supply in existence. He spurns Leroux in a final scene, has a final word on the telephone with the Comtesse; then the toxin begins to do its deadly work and in the presence of Charrier he goes through his death pangs. There has been some doubt whether the toxin acts primarily on the heart or the nerve centres. With a spasm of precordial pain—"It's the heart right enough" gasps the dying man. "Have I paid the price?" he asks, and then, after some convulsive movements, all is over, and on this scene reminiscent of the Grand Guignol the curtain falls.

The play has a propagandist flavour, and in the original is said to have caused some indignant protests among the medical profession in Paris. They are hardly likely to be repeated here. The central figure is not, happily, a type familiar to English audiences. We hope that they will not take it for granted that he is a common type in the medical profession anywhere. But, in truth, he is almost too wicked to be convincing. He loves none but himself and his career, yet he can apparently inspire sympathy both in the play, and, in the capable hands of Mr. Bourchier, among the audience. His rival, the orthodox surgeon Godefroy, is too given to lecturing people; when he holds forth at an evening party he is really rather tiresome. Dr. Charrier has also some difficulty in getting the sympathy of an English audience when he denounces the deadly sin of "dichotomy."

Mr. Bourchier has great scope for his talent in Armand Revard, as the plausible consultant, as the social lion, and in the more surgical setting of the last two acts. In the death scene he makes a big and successful bid for realism. Mr. Bourchier seems to have a *penchant* for surgical parts. We remember him some years ago in "The Knife," a one act play by Mr. Henry Arthur Jones, which was noticed in the GAZETTE of January 8th, 1910. Perhaps it is that he has a good surgical face, if we may say so without offence! His "business" when examining the patient, the details of "washing up," and the hypodermic injection, tickled the fancy of the audience. By the way, the washing up was something sketchy. Any surgeon in Dr. Revard's line of practice cannot be too rigorous about asepsis. It cannot be urged that the case was an emergency operation for hæmorrhage, and no time could be lost, as a good deal *was* lost in quarrelling with his assistant. The small part of this assistant was well played by Mr. Edmund Kennedy. Mr. Reginald Bach was appropriately insolent as the shady financier. Mr. Frank Petley did his best with the didactic speeches put into the mouth of Godefroy. Mr. Halliwell Hobbs dealt faithfully with the part of old Dr. Charrier, the only engaging character in the play.

The ladies' parts gave no great opportunities. Jessie Watson fortunately is allowed to die "off," and Miss Kyrle Bellew had no difficult task in the first two acts. Miss Carmen Nesville gave the right note of hero worship and devotion, undeterred by scruples of conscience, to the part of the comtesse.

"The Risk" is not a pleasant play, and we do not know how it may appeal to the ordinary theatre-going public, but it is sure to interest all who are acquainted with operating theatres.

Publications Received.

The Antiseptic, Abstracts of Bacteriology, Architectural Association Journal, St. Bartholomew's Hospital Journal, Bedford College Union Magazine, British Medical Journal, Burma Medical Times, The Broadway, Current Research in Anæsthesia and Analgesia, The Gong, Hospital Gazette, Hospital and Health Review, Indian Medical Record, Irish Journal of Medical Science, The Isis, London Hospital Gazette, Middlesex Hospital Journal, Medical Review, Manchester University Medical School Gazette, Medical Journal of South Africa, St. Mary's Hospital Gazette, Nursing Times, New York State Journal of Medicine, The Prescriber, The Queen's Medical Magazine, Royal Dental Hospital Magazine, The Serpent, The Stethoscope, St. Thomas's Hospital Gazette, University College Magazine.

The Dentist's Dilemma.

A world renowned cynic once remarked that "We are all strong enough to bear up under other people's misfortunes." This is true except where the other people's troubles are ours also. Then we form societies and associations of our professions and trades for our mutual encouragement and protection.

Most of the professions are interesting to write about and find their way into fiction.

The clerical is easy. For example, the vicar with the country vicarage and Ian Hay's young muscular Christian to tramp round the parish for him.

The doctor always finds a place. Scott describes the rugged country doctor "to whom Scotland owes much and to whom she is more ungrateful than to any class of men except her schoolmasters." Dickens describes the family doctor and the drunken doctor in the debtors' prison, who maintains and stimulates his resourcefulness, and that of his Gamp, by repeated applications to the port bottle. The "great eye specialist" is a favourite with the sensational novelist—not that he is ever called upon to do any eye work, but a man who can remove an eye can remove anything. He is on a plane of his own, with unlimited powers and is a very useful person to deal with any emergency which may arise in the course of the tale.

Undertakers, lawyers, soldiers, sailors, the professional waterman of the Thames and many others, all get a place.

But the dentist has not yet found his way into fiction.

The reason may not be far to seek. He is unlikely to do anything bordering on the sensational, unless the law gets him for not having shown a reasonable amount of skill; and moreover the public knows him too well.

Knowledge in dental subjects is increasing so rapidly to-day, that probably the phase is passing equally rapidly, but no doubt there was a time when the man in the street knew far too much when he visited the dentist. He knew that temporary stopping was usually more temporary than stopping. He knew that cement might come out and that amalgam should not. He did not like your plaster as he said it tickled his throat, and he did not like your composition as he said it tasted like putty. If he had cocaine "he did not come there to be pricked with a needle"—if he would have nothing, "he did not come there to have his jaw nearly broken," and if he had gas "he did not come there to be half suffocated." His wife hoped his plates would not clatter like Mr. Jones' next door, or become dislodged when he wished the family good morning.

The most restful time for the dentist was when he had him under gas—and then he had to be careful or there would be a guttural murmur from the spittoon about feeling that last one.

Nowadays with things so much advanced he gets out of his depth at times. If you tell him his teeth may be bad for his health, although they do not hurt him, and if you talk to him about apical infection, he may wonder where the catch is; should you tell him that pyorrhœa is a bad term and that his gums may be diseased although no actual pyorrhœa is present he may go away wondering if you are a fool or a knave.

The dental profession is a learned one and is becoming more learned every day, and the good dentist rivals Job in patience and requires his share of tact; he is a worthy member of society but he lends himself to fiction as easily as does the ticket collector on the Underground.

Once out of the dental chair, the public is prepared to see the humours of dentistry. During the war a travelling show called the "Dental Dispensary," toured some of the coast towns. The humour was extremely crude—a pretence of extracting with things looking like gas pliers and the fitting of a large lady into a small chair being the chief items.

In Bransby Williams' character sketch the "Old Time Showman" in which there are "just a few seats left" in his nearly empty tent, he plays very cleverly with a supposed upper plate which keeps slipping down as he tells his assistant to "put the fat woman on for two minutes" to keep up the public interest, and informs the villagers "he has come to their beautiful village for their special benefit."

Punch, of course, produces a few each year about the dentist, showing him as a gaunt individual with strong glasses and a few remaining hairs on his head, with a Scotchman in the background counting his change before submitting to gas.

The short story teller, in the music hall, works in a few—for example the old lady who, in reply to her doctor's enquiries, maintained that her teeth had not chattered, as they were in her dressing case.

During the war a naval surgeon who was a good amateur conjuror went ashore in Zanzibar to the native Bazaar to see if the natives would appreciate his tricks. He tried a few with cards and soon collected a small crowd, when a seaman elbowed his way in and removing his artificial teeth showed them to the astounded natives in his hand. He then put them back again and strolled away.

That was the best trick they had seen that day—no naval doctor or Indian juggler had ever shown them magic like that—snake charming and sword swallowing was child's play compared to this.

The sailor continued his way through the Bazaar with most of the doctor's audience chattering in his stern wake.

The doctor cleared up and went back to his ship.

E. R. BAILEY.

Glands in the Neck.

CLINICAL LECTURE BY MR. DAVIES-COLLEY.

GENTLEMEN,—Tuberculous glands in the neck are among the commonest of the surgical conditions with which we have to deal, both in Hospital and private practice, and it is because I find that the average student has very vague ideas of their pathology and treatment that I have chosen them for the subject of my lecture to-day.

The cervical lymph-nodes are arranged in two main sets, a superficial and a deep, which are separated from one another by the deep fascia. The superficial set is further subdivided into three groups, a supra-hyoid beneath the symphysis of the lower jaw, a submaxillary beneath the body of the mandible, and a somewhat scattered collection along the course of the external jugular vein situated for the most part between the margins of the sterno-mastoid and trapezius muscles. Of these three groups the first two are mainly concerned in the drainage of the buccal cavity, the teeth and the tongue, while the lymphatics of the scalp, the external ear, and the skin of the neck drain into the third. The deep set of nodes is situated along the course of the internal jugular vein in the anterior triangle of the neck, and receives the lymphatics from the tonsils, naso-pharynx, pharynx, larynx, œsophagus and trachea; also communications from the superficial groups and probably a few vessels which pass directly to them from the structures normally drained by the superficial groups. It is exceedingly important to remember the anatomy of these lymphatics because so much of the success of the treatment depends upon the localization of septic foci which are the primary cause of the enlargement of the glands.

There can be no question that the majority of infective organisms gain access to the glands by direct passage from the skin or mucous membrane, but the path of the tubercle bacilli is not quite so obvious. For while it is certainly probable that in many cases the tubercle bacilli reach the glands directly, the belief is gaining ground that in many others the blood-stream is responsible for the infection. I believe myself that the septic and tuberculous infections are intimately associated, and that a septic infection of the gland is necessary to prepare the soil for the growth of a tuberculous granuloma, and that whether the tubercle bacillus reaches the gland by direct invasion or through the medium of the blood-stream is a point of no practical importance so long as it is realised that in every child glands which are the seat of inflammation are a potential focus of tuberculous disease.

It is interesting in this connection to compare the age incidence of tuberculous disease in different parts of the system. In early childhood, when the lymphatic tissue everywhere is in an active state of growth, it is the glands that are mainly the seat of disease; later in childhood the resistance of the glands appears to increase, and with greater liability to injury the bones and joints become the common site; while in adults, with indoor occupation and lack of sufficient fresh air and exercise, the lungs become the weak spot.

Of the relative frequency of the different sources of infection about the head and neck it is rather difficult to judge. Three sources which outweigh all others in their frequency are the tonsils and naso-pharynx, the teeth, and the scalp and external auditory meatus. It is usually said that tonsillitic infections are the commonest cause of glandular enlargement, but I am not sure that this is the case. In my experience in the out-patient department, at any rate, scalp infection from pediculi, and infection from carious teeth are more frequent, but of course I do not see the bulk of the cases that come up with throat symptoms. However, there is not the slightest doubt that the prompt treatment of tonsils and adenoids which is the fashion to-day is very largely responsible for the relative infrequency of tuberculous adenitis now as compared with twenty years ago.

A question which I am frequently asked is, "How is one to know whether an enlarged gland is tuberculous or not?" When there are signs of softening or abscess formation, of course, there is usually no difficulty, but in the absence of these obvious symptoms I think one can say with certainty that a gland, which remains enlarged and easily palpable or continues to increase in size a month after the infective focus which was originally responsible for its enlargement has been eliminated, is almost always tuberculous. A chronic septic state leading to progressive hyperplasia and

gradual fibrosis of a gland after the primary focus of infection has been removed is so rare that it need not be considered, and the only instance I can remember having seen was that of a young man who had a single enlarged gland in his submaxillary region, about as big as a golf-ball, which on removal proved to be due to simple lymphoid hyperplasia. It is probable that this case should be classed as a lymphoma, an innocent neoplasm possibly started by an inflammatory process, but in no sense septic in its later development.

The other causes of glandular swellings, Hodgkin's disease, lympho-sarcoma, and leukæmia, I need only mention. The multiple nature of the swellings and their rapid and progressive growth without sign of softening is generally sufficient to render the diagnosis easy, but if it is missed it does not greatly matter, since treatment of these diseases whether started early or late has no effect on their course.

The treatment of tuberculous glands may be considered under two headings: 1. What may be called the prophylactic treatment, where there is a focus of sepsis present, and before the glands can be said to be definitely tuberculous; and 2. the treatment of definitely tuberculous glands.

1. Now I have tried to make it clear that every enlargement of cervical glands in a child must be regarded as potentially tuberculous, and as in every case of adenitis the earliest enlargement is due to simple inflammation it goes without saying that in this early stage efforts must always be made to discover and to eradicate the septic focus which is the primary cause of the enlargement. If this is done there will be little chance for the tubercle bacilli to take root and give rise to trouble. If only you will bear in mind the anatomy of the main tracks of lymphatic drainage in the neck you will have little difficulty in finding the causative focus in every case, and I shall less frequently have children referred to me with a string of glands running down the posterior triangle and a diagnosis of oral sepsis, when a single glance at the head will reveal a crop of nits perched in the most blatant way on nearly every hair of the head.

Treatment of the septic focus in this early stage is almost always followed by a rapid return of the glands to their normal state, whether the focus be the skin, teeth, tonsils, or naso-pharynx, and the treatment need not necessarily be of a very energetic nature. I believe, for instance, that tonsil and adenoid operations are often performed unnecessarily for enlarged glands, and that the wholesale removal of lymphoid tissue from the throat at an early age may possibly be the cause of lack of development of the palate with crowding of the teeth in the upper jaw, which appears to me to be on the increase. I think we undertake too lightheartedly the removal of tissues, the hyperplasia of which at this period of life points to some very definite function of which we know nothing. At the same time there is no question of the value of tonsillectomy in suitable cases; but I think that it is unnecessary in those cases in which the glands return to their normal size between successive attacks of tonsillitis.

2. Cases in which the diagnosis of tuberculous disease is certain or nearly certain.

When softening has taken place in the glands or when pus has formed outside them I believe that open operation is the only rational method of treatment, though I am aware that some surgeons advocate aspiration and, if necessary, repeated aspiration of the pus. To be successful this method must be conducted in the best of possible surroundings and must be extended over a very long period, and its tedium and the uncertainty of its final success are enough, in my opinion, to put it aside. The only question to my mind is the extent of the operation to be performed. Where it is possible there is no doubt that a complete removal of the infected tissue gives the best results, and if the pus is confined to the glands this can usually be safely undertaken. It must be remembered, however, that the operation is often a difficult one owing to adhesions between the glands and the many important structures in their neighbourhood, and it should not be undertaken by anyone who has not had a large experience in cervical surgery. Where an abscess has formed outside the glands and the tissues are widely infiltrated complete excision is often too risky an operation to attempt, or would entail so wide a removal of skin that the resulting scar would be most unsightly. In these cases it is best to open the abscess and scrape away the granulations lining its wall, and to pack the resulting

cavity with gauze impregnated with B I P P for a few days. In the case of the superficial glands this is usually sufficient, but if the pus has tracked forwards from one of the glands beneath the deep fascia it is necessary to find the opening through which the abscess communicates with the gland, and through this to scrape out with a sharp spoon the cheesy material which will be found to occupy the gland's cavity. If this is not done a sinus will persist which will need further operative treatment afterwards.

The most difficult cases for which to prescribe a definite line of treatment are those in which softening has not occurred but the glands have remained enlarged in spite of the removal of obvious sources of infection. Is one to operate in these cases, or should one adopt palliative measures, sending the child away to the country or the seaside for a long period of convalescence? There is no doubt that in perfect hygienic surroundings glands which are certainly tuberculous will yield to Nature's efforts and become, at any rate apparently, cured in time. What then is there against leaving all tuberculous glands of this class to Nature's care?

Well, there are several reasons. Consider first the risks that must be run. The glands may break down and suppurate, becoming bound by adhesions to one another and to the surrounding structures or forming abscesses, and, when these have burst, sinuses, with subsequent scarring. The tuberculous process may spread to neighbouring glands or to the muscles and skin, or even, as has occasionally happened with glands at the base of the neck, to the apex of the lung.

Again, the disease may be only partially cured, and remaining latent may break out again later, when from some cause the patient's resistance is lowered.

It must be remembered, too, that Nature's cure is at best a very slow one, a matter of months or even years, and only possible under the very best conditions, which are not easily obtained in the case of the children of the poorer classes, who are the chief sufferers; whereas excision of the glands in the early stages of infection is easy, and convalescence is short, and the cure, if the operation is properly carried out, complete.

With these considerations before us I think we must conclude that excision is the safest course and should be the rule, palliative treatment being reserved only for the most doubtful cases and for those in whom, from the nature of their surroundings, there appears to be an exceptionally good chance of a natural cure.

If palliative treatment is decided upon, a very close watch much be kept on the patient, and if any of the complications I have mentioned begins to manifest itself, operation should be no longer delayed.

There is one other point that I wish to deal with before I close. One not infrequently sees cases in which enlarged glands showing already the early signs of softening are associated with tonsils or adenoids which are obviously the infective foci, and certainly need removal. Operations on tonsils and adenoids in these cases are attended with the risk—and it is a very real one—of precipitating an acute suppuration in the glands. I have seen this happen many times, and to avoid this unfortunate complication it has been my rule for some time past, when the glands appear to be on the verge of breaking down, to excise them and remove the tonsils and adenoids at the same sitting. The raw surface left in the throat appears not to affect in any way the healing of the wound in the neck, and the risks of the double operation do not seem to be any greater than those of the single. Moreover, the patient is thereby spared the trouble and discomfort of two separate operations.

Specialities.

THE BRITISH MEDICAL PROTECTION SOCIETY,
132, Great Portland Street, W.1.

The object of the British Medical Protection Society is to obtain for its Members the payment of overdue accounts.

Mr. H. Rutherford Watson, the Managing Director, has made a speciality of this class of work for many years, and his experience enables him to deal with these matters skillfully and successfully without giving offence.

The Fee for Membership is quite a moderate one, and Members of the Medical and Dental Professions are spared both time and trouble through the services of the Society, obtaining satisfactory settlements of long outstanding accounts.

Dental Society.

At the Annual General Meeting of the Dental Society, held on Monday, May 22nd, 1922, the following Officers were elected for 1922—23:—

President—Mr. J. Lewin-Payne.

Vice-Presidents—Mr. F. J. Pearce, Mr. E. C. Hughes, Mr. F. N. Doubleday, Mr. H. Millett.

Hon. Sec.—Mr. C. H. Edney.

Hon. Treasurer—Mr. C. H. Edney.

Dental Correspondent—Mr. W. H. Foy.

Committee—

First Year—Mr. H. E. Edney.

Second Year—Mr. G. V. Lloyd-Williams.

Third Year—Mr. L. B. Osborne.

Fourth Year—Mr. C. D. Farris.

Any Year—Mr. W. Orsmond.

Mr. Martin Braun has been awarded the Prize for the best paper during 1920—21, for his paper "Diagnosis and its Importance to the Student."

A largely attended special meeting of the Dental Society was held in the Physiological Theatre on June 27th, Mr. F. J. Pearce in the chair, when a paper entitled "The Dental Pulp and Its Reactions to Injury and Disease" was given by Professor A. Hopewell-Smith.

The subject was considered from the following standpoints: The Histology and Functions of the Dental Pulp, Its Physiological Resistance to Injury, Its Reactions to Operative and Non-Operative Injuries to the Surrounding Tissues, Reactions to "Exposure," Its Diseases, Degenerations and Reactions to Senile Causes.

Regarding its histology Prof. Hopewell-Smith compared the pulp to marrow of bone, described its cells, blood vessels and nerves. He has discarded the inaccurate term "odontoblast" for reasons which he gave, and has adopted the more precise "fibriloblast" in its stead, naming the dentine-matrix-forming cells the "dentinoblasts." The peculiarities of the venous system, and the unusual characters of the blood supply generally accounted for the frequency of disease and degeneration.

The sensory nerve supply in man is probably an outcome of evolution, as in the pulps of the lower vertebrates this is considerably reduced in amount and importance. The conclusion arrived at was that the pulp serves mainly for supplying nourishment to the dentine through an exudation of lymph which passes into the dentinal tubes.

Attempts on the part of the organ to repair damage to the hard parts usually fail, because there is, amongst other conditions, a gradual reduction in its size through the layers of adventitious dentine deposited on its surface and within itself.

The diseases of the pulp included those due to (1) General Predisposing causes: (a) Heredity, (b) Sex, (c) Age, (d) Nutritional failure, (e) Long continued fevers, etc.; and (2) Local numerous predisposing causes, such as: (a) Absence of collateral vascular circulation, (b) Anatomical peculiarities of the venules, (c) Absence of a definite lymphatic system, (d) Absence of direct nervous control over the dentine, (e) The unique physical characteristics of dentine and enamel, (f) Early stenosis of the apical canal and foramen, etc. The Exciting causes are to be found in changes in the vascular and nervous apparatus and functions, as well as the results of bacterial infection of the dentine.

The frequently-recurring pulp nodules would appear to be the effects of venous hyperæmia and not the causes commonly ascribed to them. They probably resemble phleboliths in their mode of origin.

Fibroid degeneration originates in the walls of the arterioles, affects the capillaries and cells, and the nerves are ultimately involved.

The Lecture was fully illustrated by a series of lantern slides which were among the finest—if not the most beautiful ever seen at Guy's. They had been specially made by the lecturer for the occasion and were exhibited in public for the first time. A number of these slides, an album of brilliant photomicrographs, and a complete set of pathological microscope preparations with explanatory notes have been presented by Prof. Hopewell-Smith to the Society.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

London University Jewish Students' Union.

DEAR SIR,—Would you be so kind as to print, among your list of college clubs, the following:—

JEWISH STUDENTS' UNION.

President—Mr. Israel Zangwill, B.A.

Vice-President—Mr. M. L. Perlzweig, B.A.

The aim of the Club is to promote interest in general subjects of Jewish concern. Lectures, debates, socials and dances are arranged during the terms and vacations. Application for membership should be made to the *Secretaries:*—

M. Bryer, Esq., 5, King Henry's Rd., N.W. 3.

Miss O. N. Rosen, Bedford College, Regent's Park, N.W.1.

Yours truly,

O. N. ROSEN (*Hon. Sec.*).

X Rays in Obstetric Practice.

By EDWARD W. H. SHENTON, M.R.C.S.,
Radiologist to Central R.A.F. Hospital; late Senior Surgical Radiographer, Guy's Hospital.

(Reprinted by kind permission of *The Lancet*.)

The X-rays have penetrated into so many branches of medicine and surgery that, at first sight, it seems curious that obstetric practice should be almost excluded. Pelvic deformities are not difficult to detect thereby, and yet, in my experience, the aid of the rays is seldom called in. The region is a difficult one from the radiographical point of view, but it is generally possible to get useful data even if the resulting skiagrams do not rank as show pictures. I have previously pointed out how, even in a poor radiogram of the hip region, the essential lines of the upper margin of the obturator

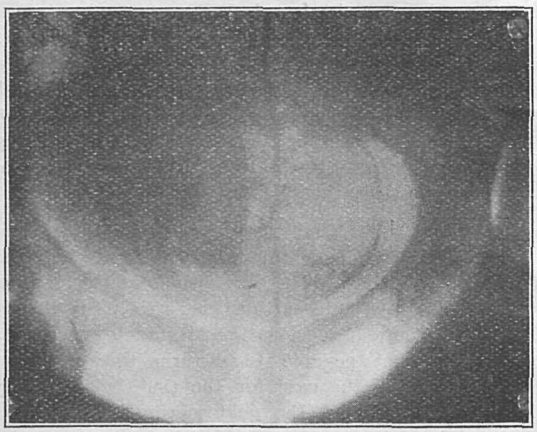

FIG. 1.

Radiogram showing relation of fœtal head to pelvis in a case in which induction of premature labour had been suggested.

foramen and the inner margin of the femoral neck will show whether there is fracture in this region by the intactness, or otherwise, of the arch formed by these two lines, and few radiograms, however faint, will fail to show these essentials. Surgeons of the present day ask for radiographic results which in their clarity would almost satisfy a common jury. They are certainly right to demand the best proofs obtainable, but I venture to think that a great deal of the more subtle and less obvious evidence is overlooked, or ignored, on this account.

In dealing with obstetrical findings one must not expect to see everything as plainly as a fractured tibia in a stereoscope. We are hampered chiefly by two conditions when radiographing the fœtus in utero. The first is the quantity of fluid, a relatively opaque medium, and the second is the paucity of mineral matter in the fœtal bones. The mineral content varies according to the age of the fœtus, but probably it will be difficult or impossible to deal with any case before the fourth month of pregnancy, and I think the fifth or the sixth will usually prove to be the earliest.

If an image, however faint, of a fœtus can be obtained, the uses of the rays are so obvious as scarcely to need enumeration—e.g., to determine (1) the presence of a pregnancy or abdominal tumour; (2) the position of the fœtus; (3) the relations of head and pelvic canal; (4) twins.

I think any gynæcologist will admit that the present methods of measuring pelvic dimensions are

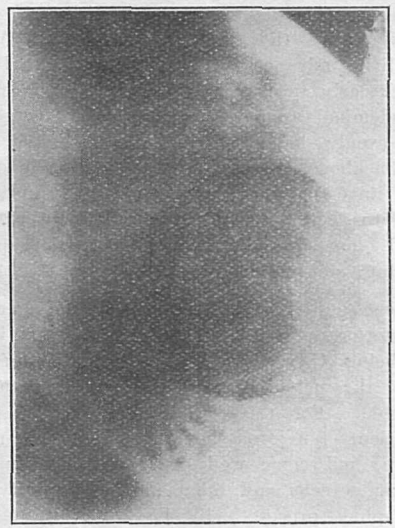

FIG. 2.

Radiogram showing abnormal position of the fœtus, which was easily rectified after X-ray demonstration.

rough-and-ready; furthermore, the relative measurements of fœtal head and the mother's pelvis are of much greater value than absolute measurement of either. Fig. 1 shows this. The patient had a small pelvis, and it was decided to induce premature labour. From this radiogram I gathered there was room and to spare. Mr. Harold Chapple, who had charge of the case, accepted the radiographic evidence, and let the case go to full time. Labour was normal and the child healthy.

This suggests a possible criticism—Are the rays in any way detrimental to the baby? I should say without hesitation "No," both from practical as

well as theoretical considerations. No harm has resulted in any case examined, and, considering the protection by fluid, as well as soft tissues, it is impossible to believe that any detrimental amount of X-rays could reach the child. Furthermore, newly-born babies show no special susceptibility to X-rays, although they are frequently examined for swallowed foreign bodies, pyloric obstruction, and various other reasons.

The second radiogram (Fig. 2), taken between the seventh and eighth months of pregnancy, shows a position of the fœtus unsatisfactory to the obstetrician, but one which was easily rectified when understood.

It is exceptional to get photographs good enough for reproduction. The initial difficulty is to secure any image of the fœtus at all, but with up-to-date appliances and the latest photographic helps I think any case can be dealt with sufficiently well to give the obstetrician the guidance he wants. And this is no little advance. A short time ago I had a case of early pregnancy, ?fourth to sixth month or ? abdominal tumour. The clinical facts seemed to be evenly balanced. An unmistakable, though faint, backbone in the first radiogram encouraged further investigations, which resulted in a complete fœtus being demonstrated. It may prove possible, I hope, to determine by radiography the exact date of pregnancy.

As some guide to technique, I would suggest antero-posterior position for head and pelvis, the latter being tilted so as to give a comprehensive view of the pelvic canal. Stereoscopy is useful if practicable. For the abdomen the lateral position, the patient lying on her side. The plate must be large, and come well over crest of ilium. Intensifying screens and other aids to rapidity in the photographic process will be essential.

I have to thank Flight-Sergeant Pattison of the R.A.F. Central Hospital for his photographic help.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Notes on a Case of Rupture of Uterus through old Cæsarean Scar accompanied by "Toxæmic" Symptoms.

Ellen T., æt. 37, multip. 7.—The first 6 pregnancies were normal and labours spontaneous. The seventh pregnancy was terminated by means of Cæsarean section, at the eighth month owing to the onset of pre-eclamptic symptoms, and twins were delivered, one cephalic, one breech (one still-born, one alive). The present pregnancy was full-time. She was seen on 23rd May, 1922, position L.O.A.; head was said to be engaged; no albumen in urine. Patient commenced labour at 1.30 a.m. on Saturday, 10th June, 1922, with one very severe labour pain from which she nearly fainted.

The card was sent up to the Hospital and the Extern arrived about 2.30 a.m. Position L.O.A., but no heart-sounds could be heard. V.E.—external os patulous, as one would expect with a multiparous woman; internal os could not be reached; but head could just be felt not properly engaged; pulse rather rapid, about 90; otherwise general condition good. Patient did not appear shocked; she had one or two pains, but it is doubtful if these were true labour pains as the uterus by this time had presumably ruptured.

At about 9.30 a.m. there was slight external oozing of blood and this continued at intervals throughout the day. The R.O. came in the evening and thought the ante-partum hæmorrhage might be due to placenta prævia or accidental hæmorrhage; but it was not possible to confirm this. It was decided to leave the case for the time being. They sent up at 9.30 a.m. the next morning (11th June, 1922) and patient was then delirious; severe pains in the epigastrium, headache, sickness, flashes of light and spots before the eyes—all typical pre-eclamptic symptoms; there had been no more hæmorrhage and no pains.

Patient was immediately admitted to Hospital. She was now quite sensible, but still had flashes of light. Albumen positive.

At about 11 p.m. patient got much worse, with very rapid pulse, and abdominal section was performed by Mr. Cook. The fœtus and placenta were protruding in inside the membranes through the old scar in the uterus into the peritoneal cavity. The head was still in the uterus, which was firmly contracted round it. Hysterectomy was performed; child was dead. There was very little internal hæmorrhage. The wound was sewn up and the patient is now doing well.

Guy's Hospital Rugby Football Club—1st XV.—1921–1922.

WINNERS OF INTER-HOSPITAL CUP.

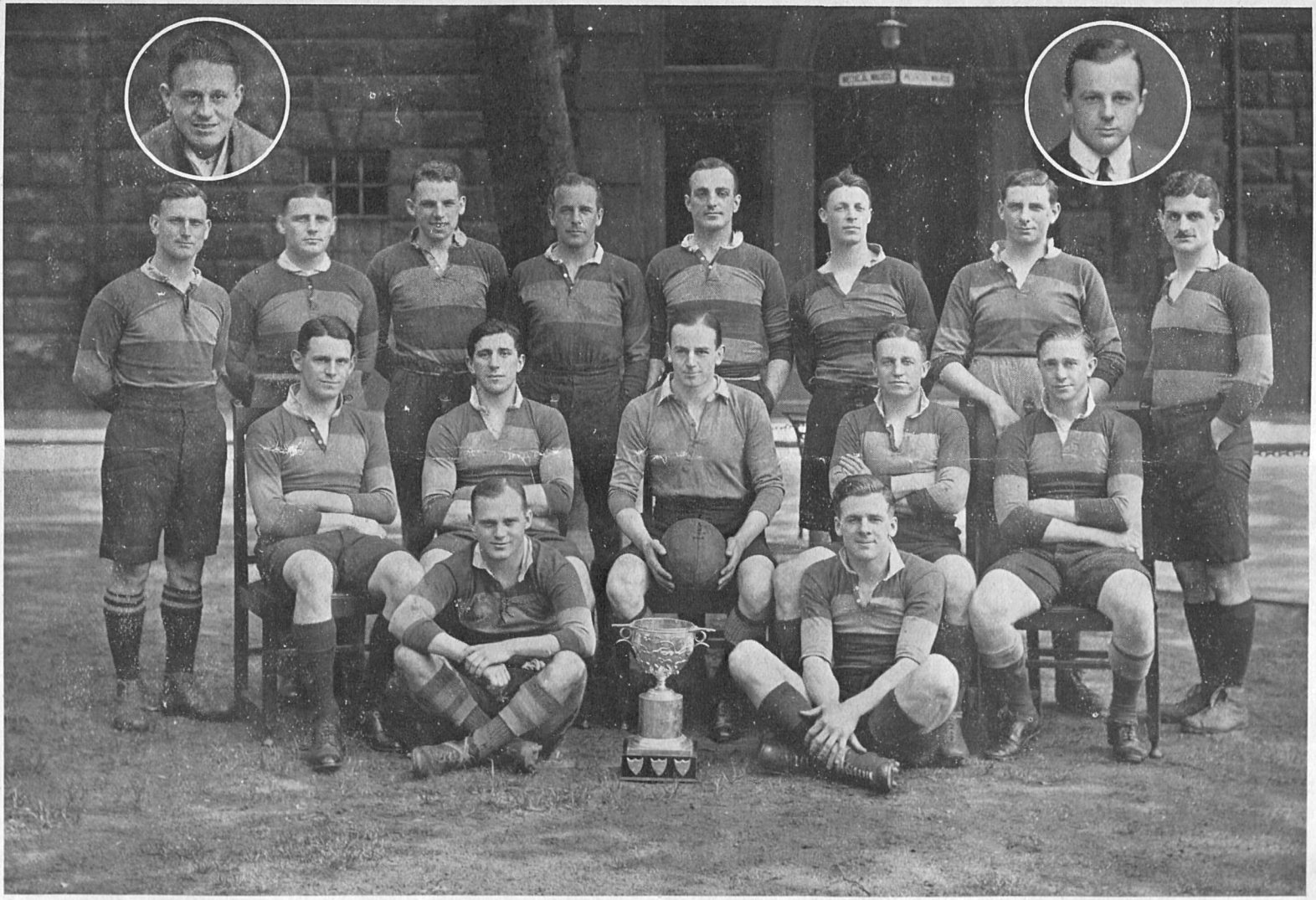

Photo by Frank S. Rolph, 93, Taunton Road, Lee. S.E.

A. B. Daneel. *(Inset.)* E. E. Neser. F. J. Biddle. *R. F. H. Duncan. E. H. Fouraker. P. K. Albertijn. E. L. Sprong. W. H Taylor. *W. D. Doherty *(Capt.)* P. G. Harvey. J. G. Van-Schalkwijk. A. K. Van-Niekerk. C. L. Steyn. F. W. Bekker. G. Zondagh. L. K. Watson. S. P. Meacock. *Inset (Hon. Sec.)*

*INTERNATIONALS

The child had probably been dead since the uterus ruptured with this first big labour pain, as no fœtal heart-sounds could be heard at any time and the patient herself had felt no movements since then, and in her own words said, "it felt like a log of wood inside her."

This is the first case at Guy's of ruptured uterus following an old Cæsarean section. There is an absurd theory that pregnancy toxæmias are an anaphylactic phenomenon dependent on certain spermatozoa. But this woman had married a second husband since her previous pregnancy toxæmia.

I am indebted to Mr. Chapple for permission to publish these notes.

R. M. L. S.

Reviews.

Biological Chemistry. Prof. H. E. Roaf, M.D., D.Sc. (Messrs. Methuen & Co., Ltd.)

The numerous recent advances in biological chemistry have produced many monographs on their own particular subjects. There is, however, still room for a text-book which brings these advances within the range of the average student.

This is the aim of Prof. Roaf's book, but unfortunately this aim has not been fulfilled. The book is divided into three sections, dealing in order with chemical and physical processes, anabolism and catabolism. The first part of the book is very badly arranged, so that many important points are relegated to footnotes while minor points have an undue prominence. The chemical equations are fairly numerous, but are set out in a form which is unintelligible to most, while they suffer at the same time from frequent errors.

The sections on anabolism and catabolism involve a general elementary account of physiology, the biochemical side being largely neglected.

Here and there we do meet with a chapter which is a contribution to bio-chemistry, such, for instance, is the chapter on enzymes; but speaking generally the book will have to be considerably revised before it finds favour with students.

Papers by Guy's Men.

C. Worster-Drought, M.A., M.D., M.R.C.P. The Treatment of Diseases of the Nervous System by Intrathecal Injection.—*Med. Press and Circular,* June 14th, 1922.

——. (And Another.) Venous Angeioma of the Cerebral Cortex.—*Lancet,* July 15th, 1922, p. 125.

Cricket.

GUY'S v. KING'S.

(Second Round Cup-Tie.)

Played at Honor Oak Park on 13th June.

The King's bowling was not good, and as the game went on it got worse. An occasional good ball was sent down, but more often than not, the full toss or yorker got the wicket. Helder at first played very steadily, scoring singletons; later on he brightened up, settled down and played really well. He hit fourteen 4's. Williams's innings was short and sweet; since the game with L.C.W. & P.'s Bank he has been scoring consistently. Before he had been in long, Wooldridge gave a chance at the wicket; he gave several more chances before being out to a difficult catch at short leg. Arkles and Biddle both played well and scored freely. We had to stop for rain just before the end of our innings. Their wicketkeeper, Gawler, and Wakeley seemed to be the only people on the side who could field at all. Strange was out at once, but Wakeley and Hall both played well and looked like making runs. Hall, a good forcing bat, had bad luck in mis-hitting a short one from Van Schalkwijk. Towards the end Gawler and Atkinson knocked up some runs, but they did not last long. Our fielding was quite fair, and both Wooldridge and Biddle bowled well.

Guy's.

N. H. Saint, lbw b Strange	5
A. G. Enor, b Gawler	13
L. B. Helder, c Gawler b Strange	100
L. S. Williams, b Sheldon	23
T. Wooldridge, c Sheldon b Gawler	48
G. D. Shaw, c Brockington b Gawler ...	3
J. Van Schalkwijk, b Gawler	15
C. Arkles, not out	60
Graham-Bonnalie, b Strange	0
G. L. Shearar, b Gawler	3
F. J. Biddle, not out	30
Extras	17
Total (for 9 wickets)	317

King's.

L. S. Wakeley, b Wooldridge	22
F. T. Strange, b Wooldridge	0
J. M. Hall, c Shearar b Van Schalkwijk ...	25
H. M. Elflick, b Wooldridge	10
R. H. Dyer, lbw b Biddle	5
W. P. Sheldon, lbw b Wooldridge	0
J. W. Kendall, b Biddle	0
F. W. Furness, run out	0

P. B. Atkinson, not out	9
F. Brockington, b Biddle	5
D. R. Gawler, c Williams b Biddle	24
Extras	8
Total	108

Bowling.—J. Van Schalkwijk, 1 for 31; T. Wooldridge, 4 for 32; G. D. Shaw, 0 for 6; F. J. Biddle, 4 for 30;

GUY'S v. ST. THOMAS'S.

(Semi-Final Cup-Tie.)

Played at Honor Oak Park, on 30th June.

We again won the toss and batted first on a "slower-than-usual" wicket. This, most probably had something to do with our low score, for some of us were playing too soon. The pace of the ground did not trouble the Thomas's batsmen because they were a decidedly better side than we were; but we ought to have made more than we did. Their fielding was keen, clean and altogether excellent, so that ours, though quite good, was poor in comparison.

Berridge, bowling a medium pace, good length ball just outside the off stump, and Doggart, fast medium, managed to keep the runs down and take wickets as well. Wooldridge batted well, as usual, and Duncan made some very nice shots. Arkles and Shearar were playing very well together and getting runs until Arkles stupidly ran himself out.

Weaver-Adams was out to a good ball, but after that, Farquharson and Jerram played very slowly, scoring only from the very loose balls. They played the right game and the score was 112 before we got our second wicket. Then Humfrey came in and hit seven 4's and a few singles. By this time Thomas's had won so we only played for a short time after this. Shaw took a good catch in the deep, and caught Humfrey well in the slips. Duncan kept wicket well and Van Schalkwijk bowled a good length to begin with, but he found it difficult to get a foothold.

Guy's.

N. H. Saint, b Doggart	9
L. S. Williams, b Berridge	6
L. B. Helder, c Canby b Berridge	3
J. Van Schalkwijk, c Canby b Berridge ...	0
T. Wooldridge, c Jerram b Doggart	41
G. D. Shaw, c Weaver-Adams b Childs ...	8
R. F. H. Duncan, b Doggart	11
C. Arkles, run out	22
G. Ensor, run out	0
G. L. Shearar, not out	30
F. J. Biddle, b Humfrey	6
Extras	4
Total	140

St. Thomas's.

S. Farquharson, c Helder b Shaw	48
E. K. Weaver-Adams, b Van Schalkwijk ...	5
N. M. Jerram, c Shaw b Biddle	70
W. M. Berridge, not out...	36
S. G. Humfrey, c Shaw b Van Schalkwijk...	36
G. K. Cooper, not out	17
Extras	5
Total (for 4 wickets)	217

Did not bat.—L. Farquharson, H. Doggart, R. Childs, L. Canby, C. Archer.

Bowling.—J. Van Schalkwijk, 2 for 64; T. Wooldridge, 0 for 36; G. D. Shaw, 1 for 32; F. J. Biddle, 1 for 30.

Guy's Hospital Rugby Football Club.

The Annual General Meeting was held in the Physiological Theatre, on Tuesday, July 11th, at 4.15 p.m.. Dr. Fawcett was unanimously re-elected President. The Officers for the ensuing year were elected as follows:—

Captain—P. K. Albertijn.

Vice-Captain—F. W. Bekker.

Hon. Sec.—S. P. Meacock.

Committee—H. Graham- Davies, W. H. Taylor, B. G. Scholefield, W. D. Doherty, R. F. H. Duncan.

It was decided to run five teams during the Season 1922—23, and Hon. Team Secs. were elected:—

"A" XV.—H. K. Williams.

Extra "A."—J. Russell.

"B."—J. G. Weston.

Nomads.—R. E. Robinson.

RESUME for 1921—22.

FIRST XV.

The fixture list was considerably longer than that of the previous season and included most of the

leading clubs in the country. A glance at the results shows how well the Hospital played throughout the season. No wonder our President says it is the most successful in the history of a club which Dr. R. M. H. Russell, in number 868 of the GAZETTE proves to be the oldest surviving rugger club.

Oxford, Devonport Services, Neath and Aberavon were the only teams not defeated, but it is generally agreed that in the case of Oxford the home side were very unlucky and that so superior a side has very rarely lost. Cambridge were twice defeated and thus our performances against the Universities of the previous season were reversed.

Of the other clubs that defeated the Hospital all were beaten at one of the two encounters. Whilst all the London clubs were unsuccessful in their meetings with the Hospital.

The club's greatest day was undoubtedly on December 17th, when Cardiff were defeated on their own ground; the Hospital side being without the services of R. F. H. Duncan, P. G. Harvey, W. H. Taylor and L. K. Watson, all of whom were playing for the South of England at Bristol. E. E. Neser was also out of the side. The example of the United Services in playing two XV.s was tried with success, as in spite of the fact that the team was visiting Cardiff a home XV. managed to defeat the Old Millhillians at Honor Oak Park.

One home and one away match were scratched owing to the hard grounds resulting from the prolonged summer. So the United Services did not visit Honor Oak Park, and it fell to the game with Bristol to be the first home game and the first to fill the new stand. On no occasion was the seating accommodation inadequate, so well has this stand fulfilled the need of the past few seasons. A row of raised foot-boards behind the old ones has further added to the comfort of the spectators and increased the capacity of the gate.

The Inter-Hospital Cup was retained; Middlesex, Bart.'s and London being defeated, after drawing a bye in the first round.

The Easter tour proved to be a very pleasant holiday for all who took part, although the results of the matches played were largely anticipated owing to staleness at the end of so strenuous a season.

W. D. Doherty captained the side for the third year in succession; J. A. Krige only appeared twice as vice-captain as he returned to South Africa upon obtaining his Dental qualification. Of those who played for "the South," W. H. Taylor and R. F. H. Duncan also played for "the Rest" at Twickenham, and the latter was included in the English pack on three occasions. Injuries sustained in the second match of the season robbed the Hospital of the services of a very heavy forward in Maree, whilst E. L. Sprong, at outside half, was the great acquisition of the season.

The season closed with a very pleasant evening at Oddenino's, on the occasion of the Annual Dinner on May 17th. All present were convinced that it was a very "*schucchesshful sheashon!*"

				For	Agnst
Sept. 17	Catford Bridge	A		33	0
„ 24	Coventry	A		9	8
Oct. 1	Old Leysians	A		Scratched	
„ 8	United Services	H		Scratched	
„ 15	Gloucester	A		0	13
„ 21	Bristol	H		8	3
„ 29	Harlequins	A		14	6
Nov. 6	Old Blues	H		8	3
„ 9	Cambridge University ...	A		16	12
„ 12	Coventry	H		25	0
„ 19	Plymouth Albion	H		6	3
„ 26	London Scottish	H		14	6
„ 30	Oxford University	H		9	10
Dec. 3	Swansea	H		9	0
„ 6	Devonport Services	H		0	0
„ 10	Old Alleynians	H		46	0
„ 17	Cardiff	A		10	8
„ 17	Old Millhillians	H		25	3
„ 31	Rosslyn Park	H		17	13
Jan. 7	O.M.T.	H		26	6
„ 11	Royal Air Force	H		6	5
„ 14	Bristol	A		3	8
„ 18	Cambridge	H		18	0
„ 28	Gloucester	H		20	5
Feb. 4	Blackheath	A		7	3
„ 11	Plymouth Albion	A		0	6
„ 13	Devonport Services	A		6	8
„ 16	Middlesex			23	0
„ 18	Richmond	H		6	0
Mar. 2	Bart.'s			17	0
„ 15	London			42	6
„ 22	United Services	A		15	3
„ 25	Swansea	A		3	3
April 1	Northampton	A		9	0
„ 15	Neath	A		0	7
„ 17	Aberavon	A		3	11
„ 18	Maesteg	A		14	9

Matches played, 35. Won, 26. Drawn, 2. Lost, 7.

Points for, 467. Points against, 162.
Percentage, 77%.

"A" XV.

Played 21; won 10; lost 11.

The "A" team did not fulfil its early promise annd by no means followed the brilliant example set by the 1st XV. It is hoped that in this coming season a better display will be given, especially as one of our experts one evening recently sounded a

solemn warning (emphasising it about six times in as many minutes) that "the "A" of next season will be the 1st team of the season after"—unless, of course, a liberal supply of star three-quarters is forthcoming from "down under."

We retained the Junior Hospital Cup without meeting any very serious opposition. In the Senior Kent Cup, however, we were not so fortunate and did not get beyond the first round.

"B" XV.

Although the results were not so good as in 1920—21, last season was quite successful. We played 21 games, of which we won 12, lost 8 and drew 1—points for 273, points against 118. Our most serious defeat was by the R.N.C. "A," in the 1st round of the Junior Kent Cup. Throughout the season we had difficulty in filling the half back and centre three-quarter positions, so that our backs lacked really good combination. S. H. Daneel, at full back, was as safe as ever, and was also a most efficient captain. The pack was light, but was fast and could handle well on occasions. We missed a leader in the early part of the season, but later J. A. Gurrie was able to fill the part.

Team—S. H. Daneel (capt.), J. C. Yong, W. Orsmond, J. H. Walters, W. H. Craib, J. Jemson, E. H. Berry, J. A. Currie, V. R. Estment, E. Orsmond, C. Ive, N. L. Eckhoff, A. Russell, R. D. Gross, F. Brayfield.

NOMADS XV.

The Nomads had quite a successful season, the results of the matches were as follows:—

Played 18; won 10; lost 5; scratched 3.

We wish to thank members for turning out so well—there were always plenty of players and the difficulty was in picking the team, because there were so many people of very much the same standard.

We tried to play people more or less in turn, but of course that had its disadvantages in that the same team were not playing all the time.

There were some complaints about the Nomads always playing "away"—the 1st, "A" and "B" get preference for playing at home and very few days are left when their fixtures have been made.

Next season it is possible that Kent County may have a ground on which junior teams can hire pitches and so entertain some of their opponents. If this happens the Nomads will be able to have home matches on their list. Up to now nothing definite has been arranged by the County.

We wish to thank members for their keenness in turning out and hope they will show the same spirit in the coming season.

Guy's Hospital Golfing Society.

Results of Monthly Spoon played at the West Kent Golf Club, 12th July, 1922.

		Gross.	Hcap.	Net.
1.	S. C. Rowbotham	95	16	79
2.	L. W. Cann	88	8	80
	D. G. Bown	94	14	80
4.	F. W. Schofield	95	14	81
5.	G. W. Gathergood	95	11	84
6.	K. Hooper	98	4	94
7.	E. E. Neser	115	18	97
	T. A. Shaw, J. C. G. Dickinson	No cards returned.		

Appointment.

Arthur J. McNair, M.B., B.Ch., F.R.C.S. Eng., Assistant Obstetric Surgeon to the City of London Maternity Hospital.

Birth.

POULTON.—On June 29th, 1922, at The Downs, Woldingham, Surrey, to Dr. and Mrs. E. P. Poulton—a daughter (Penelope).

Marriages.

BRIGGS—DAMS.—On July 18th, 1922, at the Parish Church, Henley-on-Thames, by the Rev. A. E. Dams, M.A., Rector, assisted by the Rev. A. Briggs, M.A., Rector of Keston, Kent, Percy James Briggs to Marjorie Kathleen Dams.

TONKIN—HANDLEY.—At Pietermaritzburg, Natal, Bertie Moorwood Tonkin, L.R.C.P., M.R.C.S., L.D.S.Eng., son of Mr. and Mrs. H. Vincent Tonkin, Greytown, Natal, to Iris Viola Rosemary Handley, youngest daughter of the late Mr. and Mrs. T. L. Handley, "The Folly," Greytown.

WEBB—BODENHAM.—On June 20th, 1922, at the Church of the English Martyrs, Streatham, Harold Webb, M.R.C.S., L.R.C.P., of 10, Egerton Road, Bexhill, to Margaret, daughter of Mr. and Mrs. J. R. D. Bodenham, of Northendene, Streatham Common.

YOUNG—VINSON.—On Monday, July 17th, 1922, at St. Stephens, Walbrook, by the Rev. R. S. de C. Laffan, Graham Salter Young, son of John Young, Esq., M.D., Burfords, Bishop Stortford, to Nora Eveline Vinson, widow of the late Capt. A. H. Vinson, R.F.C., of Belvedere, Kent.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Ninetieth Annual Meeting of the British Medical Association, held at Glasgow, of which a report will be found in the supplement to the *B.M.J.* for July 29th, 1922, reveals a great divergence of opinion on the subject of payment of Hospital Staffs.

At the meeting at which this question was discussed, there seemed to be no unanimity on the part of the speakers. One would cling to his faith in the voluntary system, another would announce that this was already dead. One would oppose the payment of honorary hospital staffs on the ground that no further drain on hospital funds was desirable at the present moment, while another would announce that there was now no need for the maintenance of hospitals for the benefit of the indigent, the poor being "no longer with us"!

In spite of this chaotic state of affairs, the decision of the meeting not at present to proceed with the motion of its own Council demanding payment for services rendered to voluntary hospitals, is important, in that it indicates a general mistrust, on the part of the meeting, of a measure which would so completely alter the status of the hospital physician or surgeon.

We would not put it quite so strongly as *The Times* does when it makes the statement that payment of hospital staffs is the earliest step in the control of these staffs by the State, but it is quite evident that the hospitals are not in a position to adopt at present any radical alteration of this nature.

The Honorary Staff of a large General Hospital represents the aristocracy of the profession —the brains of medicine, just as general practitioners form its backbone. The man who succeeds in becoming a member of the Hospital Staff thereby acquires prestige and experience which to a great extent balance the free services given. The hospital physician or surgeon does a great deal of his best work for people who are unable to pay him, but he must find his position worth while. If this were not so we should not see men so often staying on at their Hospital, at the cost of great financial loss to themselves, in the hopes of a staff appointment and the ultimate benefits to be derived therefrom. Since this is the case there seems to be no real reason for effecting a fundamental change, at present, in the position of hospital staffs.

One recommendation made at the meeting is certainly worth consideration. The junior staff appointments in hospitals could certainly be better paid than they are. No fundamental alteration of status is involved in making these appointments well paid, and their assistance to the future aspirant to staff honours would be greatly enhanced if they afforded the holder a decent competence.

We have heard, recently, a complaint that many men who are qualified to compete for the various medals and prizes for senior students (such as the Treasurer's Gold Medals for Clinical Medicine and Surgery, the Golding-Bird Medal and Scholarship for Bacteriology, and the Beaney Prize for Pathology) do not do so, owing to the fact that they are labouring under a misapprehension as to what constitutes eligibility.

The conditions under which men may compete for these prizes are stated quite plainly in the little green books which may be obtained at the Medical School Office. In these, we see, it is stated that these prizes are open for competition by students, *whether qualified to practice or not*, who have pursued their clinical studies in the wards of Guy's Hospital for not less than eighteen and not more than thirty-six months, such period being calculated from the commencement of the appointment of Surgical Ward Clerk.

The conditions permit a student to compete during a fairly extensive part of his hospital career, and we make them public, in the belief that an assiduous study of the green books mentioned above is not a very common practice among Guy's students.

It is our sad task to record this week the death of two Guy's men.

Dr. Gerard Wetherell Capron Hollist, who entered the Hospital towards the close of the last century, and qualified in 1903, died at Lowestoft on July 23rd.

Dr. Charles Henry Brooking, the centenarian, died at Paignton on July 16th. He formerly practised at Brixham and is one of the last of the Volunteers of 1852.

On the occasion of his attaining his hundredth birthday, Dr. Brooking received congratulations from the Council of the Royal College of Surgeons. It will be rembered that a congratulatory note was inserted in these columns at the time.

Not long ago we published a series of articles under the heading "When the Gazette was Young." These were written by an old Guy's man, one of the earliest editors of the Gazette, and their richly reminiscent tone and wealth of happy details have delighted many of our readers, both past and present Guy's men.

It has been our good fortune to secure a further contribution dealing with life at the Hospital fifty years ago. The new series begins in this issue, and we can assure our readers that they will find it as interesting as its predecessor.

We congratulate the Nurses' Tennis Team on their victory over the London Hospital in the competition organised by the *Nursing Times*. Last year they were defeated by the London team in the final. Their defeat of an almost identical team this year is a most praiseworthy effort, and we do not know which to commend the more, the initial success of the "A" team, or the fine rally of the "B" team, which turned defeat into victory at the last moment. Details of this match and of the Nurses' Swimming Club's Sports will be found on page 336.

The farewell dinner to Mr. Joffe, held at Oddenino's Restaurant, was a great success, although unfortunately Mr. Hughes was prevented by illness from attending.

We are all sorry that Mr. Joffe is leaving the Hospital. Apart from his great ability as a teacher, those who have worked under him have come to regard him as a friend, and his loss is one which will be greatly felt by all the

ex-dressers and ward clerks of the Steward firm, and by the many others who have known him.

We wish him the best of luck in his new work in Johannesburg.

QUITE recently Dr. Waldo, J.P., the Coroner of the City of London and Southwark, was the recipient of congratulations, from many sources, on the completion of twenty-one years' service as Coroner. Dr. Waldo has worked in the Research Laboratories of Pasteur, Koch, and Pettenkofer; he was the first M O. H. for the Two Temples, and tutor in Public Health at St. Bartholomew's Hospital; Milroy Lecturer to the Royal College of Physicians and Lecturer on Medical Jurisprudence to the Council of Legal Education. A mere list of public and academic distinctions, however, can give no indication of the real reasons for Dr. Waldo's popularity. It is his solicitude for the public welfare that has earned for him the admiration of so many people.

Dr. Waldo during the course of his career has been responsible for many of the improvements in South London's worst slums. He recognised that Tabard Street, Red Cross Street, and adjacent alleys were, in effect, a cesspool of disease and immorality. His criticisms and his actions sometimes brought him into opposition with the Councillors, but he persevered until improvements were effected. Since he has been Coroner, Dr. Waldo has drawn public attention to the dangers of the crowded streets and the insanitary houses that still remain. (Incidentally we may mention that in his early days as Coroner he committed for trial the notorious poisoner Klosowski—alias Chapman—who was afterwards executed.)

Every House-officer at Guy's comes into contact with Dr. Waldo at some time or other. And there are some who, by reason of his pertinent questions in awkward cases, have come to regard an interview with him as one of those trials which we mortals have to bear, but certainly do not enjoy.

None, however, fail to appreciate the fairness with which he conducts his cases. We know that Dr. Waldo has always had the welfare of Guy's at heart, and join sincerely in the chorus of congratulations.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Rupture of Uterus through Cæsarean Scar

DEAR SIR,—In the last issue of the GUY'S GAZETTE, under the heading of "Notes on a Case of Rupture of the Uterus through an old Cæsarean Scar," the statement is made that this was the first case of a like nature that had occurred at Guy's. This is not correct, and it may be of interest to you to record a previous one, though I must do so from memory as I have no reference to the notes.

Whilst I was Extern in 1897, a case of a primipara occurred in the Charity of transverse presentation with Bandl's ring contraction, on whom, after unsuccessful attempts at delivery, Cæsarean section was performed by the late Dr. Horrocks in Dorcas Ward. In 1900, whilst I was Obstetric Resident, this same patient was sent into the hospital by a doctor outside the district. She had commenced labour at full term, a foot was presenting at the cervix, and she had severe abdominal pain with rapid pulse and signs of intra-abdominal hæmorrhage. A large bipolar mass could be felt in the abdomen, and upon laparotomy by the late Mr. Targett this was found to be partly the uterus and partly the fœtal head which was protruding through the rupture of the previous Cæsarean scar in the anterior uterine wall. The dead child was removed, and hysterectomy performed. No doubt the notes of this case are preserved in the volumes for these years.—Yours truly,

R. H. JOCELYN SWAN.

75, Wimpole Street, W. 1.
July 28th, 1922.

Change of Address.

K. H. Hole, M.B., B.S., Surgeon Commander, R.N., Royal Naval Hospital, Plymouth.

Gastro-Enterostomy in Pyloric Obstruction.

THE after history of cases of gastro-enterostomy from the patients' point of view cannot fail to be of interest; in this case, however, it is made the more interesting, partly from its historical standpoint owing to the fact that the operation was done as long ago as 1895, with a Murphy's button which I hope and believe is now obsolete as a method of junction in these cases, and secondly from the fact that the symptoms of pyloric obstruction are now so early recognised and its surgical treatment so quickly adopted that the classical symptoms of the dilated stomach of those days with all its attendant horrors are no longer prevalent. At the date when this case was operated on, viz., December, 1895, the symptoms of obstruction had been going on for over a year, and no operation had been suggested as a relief; medical treatment, i.e., dieting and lavage alone had been adopted with but indifferent results. This was undoubtedly due to the hesitation of the physician to call to his aid his co-adjutor or complement —the surgeon. Thank goodness a new era has arisen, and there is, I am glad to say, no need now for the appeal I made in the *Lancet* of September, 1896, for the early recognition that pyloric obstruction due to cicatrisation of pyloric ulcer is essentially a surgical rather than a medical case.

For over a year the most horrible sufferings were endured, the vomiting of *gallons* of fermenting frothy brown fluid, great thirst, no appetite, eructation of vile gases, wasting (from 12 stone to 7½), life was a misery, and work a nightmare.

On December 5th, 1895, an anterior gastro-enterostomy was performed under A.C.E. by means of a Murphy's button The recovery from the operation was phenomenally quick, for a visit was made to the Empire and supper at Scott's on the 14th day, and a journey made into Cornwall on the 19th day, and work was resumed at the end of 5 weeks.

The interest in this operation is centred to some extent in the fate of the button. What had become of it? There was no discomfort of any kind, except perhaps some constipation, which was relieved by doses of cascara The benefit that I derived from the operation was in some respects immense, the sickness, the eructations, the all consuming thirst and lassitude were relieved beyond measure, but some gastric stasis with fermentation remained behind to trouble me for years, necessitating careful dieting and occasional lavage. What had become of the button? In order to try and locate it on two occasions X-ray photographs were taken, but without success. With certain limitations life was made more or less endurable by the operation till August, 1906, when I was seized with an attack of appendicitis, leading to a large stinking abscess, which was opened and the appendix removed. The question o the origin of this attack is of importance in so far as it might throw some light on the situation of the Murphy's button, for though its presence was not discovered, nor thought of as far as I was concerned, yet the importance of the local trouble must not be overlooked, as will be seen later on. However, I soon recovered and got back to work again in something like seven weeks; recovery being somewhat delayed by a sinus. Soon after my recovery from the attack of appendicitis I began to have attacks of fixed pain coming on at 11 o'clock, 4 o'clock, and 9 o'clock, situated below the ninth central cartilage, spreading upwards to the right breast and horizontally round under the right arm. There was always a fixed spot on which one could put one's finger-tip as the centre of radiation. Its character was boring, piercing, lancinating, and lasted till it was relieved after a time by doses of carbonate of magnesia, or by food, or by vomiting, or by lying down, in fact it was the usual frequently described hunger pain, but it was quite unusual for it to keep me awake at night.

The pain, however, remained continuous until after some two years, when the pain centre shifted to a point in the mid-axillary line on the right side level with the right nipple. The pain was severely aggravated by aperients, lasting continuously for a week at a time when any was administered, so that as constipation existed, I lived between the devil and the deep sea.

Life began to be such a burden that it was impossible to stick it, so in January of 1911 I consulted Sir Charters Symonds, and arranged that Dr. Jordan should X-ray a bismuth meal. No wonder that there was so much pain, for he found:

1st. That the gastro-enterostomy stoma had closed, and no food passed through it.

2nd. After 8½ hours the stomach contained quite half the bismuth meal.

3rd. That there was no antrum pyloris, the pyloric termination having a constricted conical form through which a little of the bismuth was seen to leave the stomach below the conical termination.

4th. The stomach appeared enlarged and dropped.

No doubt the pain was due to the violent contraction of the walls of the stomach attempting to drive the food through the constricted pylorus.

Mr. Symonds advised a fresh gastro-enterostomy, and this was performed on February 15th, 1911. The site of the old operation was not interfered with, but a fresh opening was made to the left of the old operation, leaving everything "in situ." In addition an inter intestinal junction was made below to prevent if possible the regurgitation of bile which had been such a drawback after the first operation in 1895.

From this operation recovery was made without a bad symptom until the 17th day when I was seized with violent griping pains and sickness lasting 24 hours. As I had had a quail for supper it was supposed to be the offender, and I was dosed by the R.M.O. with castor oil. However, it passed off and two days later I went out of Bright into Cornwall for three weeks change.

While in Cornwall I had several severe attacks of gripes and very many slight attacks, but these were attributed to indiscretions in diet.

During the next few months, April, May and June, 1911, attacks of pain of more or less severity became frequent. About the 20th June very severe paroxysms of pain became almost constant, attacking me too at night and waking me up. I began to realize that the pain attacked *one* portion of bowel, commencing above and to the left of the umbilicus, and gradually ending abruptly close to the old appendix scar. On the 26th 27th and 28th June, the pain became constant and almost unendurable. At the same time I realized that a portion of intestine was permanently distended and palpable, with intense peristalsis.

Fig. 1.

I then went into Bright, and on June 30th was operated on by Sir Charters Symonds for the obstruction. After a good deal of manipulation,—for up to now the cause was in doubt,—he found by tracing the distended bowel down to the cæcum, that there was a lump of considerable size at the junction of the ileum with the cæcum. This had to be explored which could only be done by slitting up the ileo-cæcal valve, and there, firmly embedded in the valve he discovered the remains of the Murphy's button, and that this with the surrounding infiltration, thickening and granulation tissue had so narrowed the lumen of the valve as to make it almost impassable.

After its extraction which was a matter of considerable difficulty and necessitated an ileo-colic junction higher up, recovery was rather delayed by an unfortunate stitch abscess, but a very few weeks sufficed to put me on my legs again.

Several interesting questions arise out of the narration of the history and disinterment of this once popular but now discredited mechanical contrivance, viz., first, where

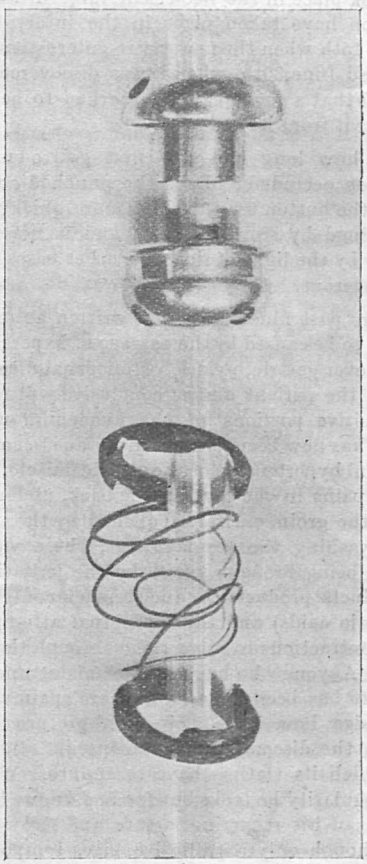

Fig. 2.

had it been all this time (between 15 & 16 years)? Had it lain dormant in the duodenum and was it released by the manipulations connected with the second gastro-enterostomy? Certainly this operation marked the onset of acute pain and the first symptom of obstruction. Did the pain which was experienced before the second gastro-enterostomy and came on some hours after food, probably when the food was passing through the pylorus into the duodenum, point to the possibility of the button being there.

Can it be explained that three X-ray photographs were taken, one quite recently (January, 1911), and yet failed to locate the position of the button, especially if it was in the duodenum? On the other hand, had it always been embedded in the ileo-cæcal valve? and if so what caused the onset of the acute symptoms? and how was it that it had never caused trouble before, excepting possibly constipation? Was its presence there the cause of the attack of appendicitis in 1906? or was it not more probably due to the general intestinal toxæmia arising from fermentative changes in the food both in the stomach and bowel? Could the marked changes which took place in the ileo-cæcal valve in and around the button have taken place in the interval between February 15th when the new gastro-enterostomy was performed and June 30th, when it was discovered so firmly embedded that a good deal of force had to be exercised to disinter it from its bed?

Again, how long had the first gastro-enterostomy stoma been occluded? Does the punched-out opening made by the button tend to close more quickly than the one obtained by simple suture, and is not so large? Certainly by the light of this and other cases it is much more dangerous.

In years past much has been written as to the pain supposed to be caused by the passage of hyperacid gastric contents over gastric, pyloric or duodenal ulcers. Pain, which to the patient almost conclusively proved to him that sensitive portions of the duodenum were being irritated, has now been proved to be due to contractions and painful hypertension of the gastric muscle. I, myself, have had pains in the loin, in the back, under the arm, down in the groin, entirely abolished by the simple process of washing the stomach out, these violent contractions being brought about by the irritation of the acid products produced in the stomach contents (lactic and butyric acids) and the ineffectual attempts of the gastric contractions to drive them through the narrowe pylorus. Anyone who has had the misfortune to suffer from what has been called "hunger" pain will readily acknowledge how little this word-picture accurately describes the discomfort amounting in some cases to agony which its victims have to endure. With monotonous regularity he looks out for and knows the earliest symptoms of his recurring torture, and seeks something which, though only a palliative, gives temporary relief. In my own case, notwithstanding the fresh gastro-enterostomy, I suffered from regular attacks of hunger pain, coming on with the regularity of clock-work at 11 o'clock, 3 and 6 o'clock, and I attribute them to the accumulation of the acid products of fermentation in the pyloric portion of the stomach, which owing to its sagged condition acted as a cul-de-sac. My reason for attributing the attacks to fermentation products rather than to hyperchlorhydria is that notwithstanding the administration of belladonna and olive oil and lavage they persisted until in 1915, when I was knocked down in a darkened street by a van, and used a large bandage to support my back and lower abdominal walls. This gave so much relief that I adopted a Walton & Curtin belt with very much benefit.

In the act of digestion in the stomach the food is driven down by the firm contraction of the fundus into the pyloric antrum, and waves of contraction are there excited with a view to the extrusion of the fluid acid contents through the pylorus into the duodenum, in my case without avail, consequently the contents become more and more acid as the retention continues and fermentation takes place to add to the irritative qualities of the gastric contents. It must be remembered that the new opening as a substitute for the pylorus is situated in the body of the stomach, and the physiological action of the stomach is to some extent ineffective owing to the obliteration of the pyloric opening, and or much sagging of the dilated stomach. It has occurred to me that this operation of gastro-plication might be usefully employed in this condition. During the years 1919 and 1920 I began to have recurrent attacks of pain accompanied by sickness and tenderness situated just below the 9th right costal cartilage. These in most cases lasted perhaps 1, 2, or 3 days, and were relieved by fasting, rest, and hot applications. The climax came, however, on Dec. 29th, 1921, when the pain and vomiting resisted such simple measures, and the vomiting became fæcal, and the operation for the relief of some obstruction became imperative. Mr. Slesinger operated and found the entero-colic anastomosis obstructed by a band of omentum and general adhesions. These were freed and the stagnant contents of ascending colon massaged on past the anastomosis into the transverse and descending colon.

It would have been surprising if my stomach had not been permanently affected, which indeed is the case. There is now (1922) complete achylia and lack of motor activity, the stomach not emptying itself under six hours. Some sort of digestive power is being given by the exhibition of dilute hydrochloric acid in 40 minim doses combined with ten grains of Armour's Pepsin with each of the principal meals.

The avoidance of fermentative changes is assured by night and morning lavage. By these means life is made endurable, considerable amount of work is possible, sleep is obtainable, and a slight, very slight, gain is made in body weight.

Looking back at the chain of circumstances which conduced in regular sequence to bring about a concatenation of events enough to destroy the usefulness and happiness of a life, one can easily trace the interdependence of one link with another.

Leaving Hospital, I went into a partnership which turned out a failure, then embarked on another, and then followed eleven years without a holiday in a struggle for existence followed by hyperchlorhydria, duodenal ulcer, cicatrisation, pyloric obstruction for over a year, and eventual relief by gastro-enterostomy in 1895, then the appendicitis in 1906, a second gastro-enterostomy in 1911, with its complementary obstruction from the

Murphy's button the same year; the operation in 1921 completing a list of which these are the principal events, but with a background of suffering in the intervals which would be difficult to describe, difficult to understand, and more difficult still to find a reason for.

M.R.C.S.

Appointments.

Guy's Hospital Medical School.

The following appointments and re-appointments have been made by the Treasurer upon the recommendation of a Staff Meeting (to date from October 1st, 1922).

Dental Radiologist.—Mr. H. H. Worth, L.D.S.

Dental Bacteriological Assistant.—Mr. A. Bulleid, L.R.C.P., M.R.C.S., L.D.S.

Demonstrators of Prosthetic Dentistry.—Mr. E. L. Messenger, L.R.C.P., M.R.C.S., L.D.S.; Mr. K. G. Sharvill, L.D.S.

Dental Officer to Salomons Centre.—Mr. E. R. Bailey, L.R.C.P., M.R.C.S., L.D.S.

Demonstrators of Operative Dentistry.—Mr. H. G. R. Canning, L.D.S.; Mr. A. L. Spencer-Payne, L.R.C.P., M.R.C.S., L.D.S.; Mr. A, B. Aldred, L.D.S.; Mr. B. C. Woodroffe, L.D.S.; Mr. J. A. Snarey Wright, L.D.S.; Mr. E. H. Bryant, L.R.C.P., M.R.C.S., L.D.S.

Dental Anæsthetist to Salomons Centre.—Mr. A. D. Marston, L.R.C.P., M.R.C.S., L.D.S.

Assistant Anæsthetist to the Dental School.—Mr. R. B. P. Lansdown, M.B., B.S.

Medical Registrars and Tutors.—Mr J. J. Conybeare, M.B., M.R.C.P.; Mr. A. H. Douthwaite, M.B., B.S.; Mr. M. Maizels, M.B., B.S.; Mr. H. St. H. Vertue, M.A., B.M., B.Ch.

Surgical Registrars, Tutors and Assistants.—Mr. T. G. D. Bonar, M.B., B.S. (to Sir Alfred Fripp); Mr. Grant Massie, M.B., B.S., F.R.C.S. (to Mr. Rowlands); Mr. Gaymer Jones, M.B., B.S., F.R.C.S. (to Mr. Steward).

Demonstrators of Physiology.—Mr. J. M. H. Campbell, M.D., M.R.C.S.; Mr. D. J. P. O'Meara, L.R.C.P., M.R.C.S.

Demonstrators of Anatomy.—Mr. W. H. Ogilvie, M.A., M.Ch., M.B., F.R.C.S.; Mr. W. D. Doherty, B.Ch., L.R.C.P., M.R.C.S.; Mr. V. E. Lloyd, M.B., B.S.

Demonstrator of Pharmacology.—Mr. H. St. H. Vertue, M.A., M.B., B.Ch.

Demonstrators of Pathology.—Mr. R. D. Passey, M.D., D.P.H.,; Mr. E. Biddle, M.B., B.S.

Demonstrator of Biology.—Mr. L. C. Fox, M.A.

Griffiths Demonstrator of Patholigy.—Mr. F. J. Carter-Braine, M.B., B.S., F.R.C.S.

Anderson Demonstrator of Clinical Chemistry.—Mr. W. W. Payne, M.B., B.S.

Demonstrators of Chemistry.—Mr. H. C. Bell, M.A.; Mr. G. M. Bennett, B.A., M.Sc., M.A., F.I.C.; Mr. J. Wiseman, B.Sc.

Demonstrator of Physics.—Mr. T. W. Adams

Medical Assistants.—Mr. A. A. Osman, L.R.C.P., M.R.C.S.; Mr. W. W. Payne, M.B., B.S.

Chief Clinical Assistant and Registrar, Ophthalmological Department.—Mr. O. G. Morgan, M.Ch., F.R.C.S.; Mr. C. H. St. John, L.R.C.P., M.R.C.S., D.O.M.S. (to Mr. Ormond).

Chief Clinical Assistant and Registrar, Throat and Ear Department.—Mr. N. E. Kendall, M.R.C.S., L.R.C.P.; Mr. C. Gill-Carey, M.R.C.S., L.R.C.P.

Chief Clinical Assistant and Registrar, Neurological Department.—Mr. A. H. Douthwaite, M.B., B.S.

Chief Clinical Assistant, Children's Diseases Department.—Mr. A. A. Osman, L.R.C.P., M.R.C.S.

Chief Clinical Assistant, Actinotherapeutic and Electrical Department.—Mr. J. F. Carter-Braine, M.B., B.S., F.R.C.S.

Junior Assistant Bacteriologist.—Mr. E. Biddle, M.B., B.S.

Resident Medical Officer, Bright Ward.—Mr. K. M. K. Duff, L.R.C.P., M.R.C.S.

Anæsthetist to Bright Ward.—Mr. E. A. Scott, L.R.C.P., M.R.C.S.

Assistant Anæsthetists to the Hospital.—Mr. N. E. Kendall, L.R.C.P., M.R.C.S.; Mr. R. B. P. Lansdown, M.A., M.B., B.Ch.; Mr. D. J. P. O'Meara, L.R.C.P., M.R.C.S.; Mr. E. F. Wilson, L.R.C.P., M.R.C.S.

Orthopædic Registrar with Charge of Workshops.—Mr. A. H. Todd, M.S., F.R.C.S.

Chief Clinical Assistant to Obstetric Surgeons in V.D. Department.—Dr. M. Rawlins.

Obstetric and Gynæcological Registrar.—Mr. A. J. McNair, B.A., M.B., B.Ch., F.R.C.S.

Farewell Dinner to J. Joffe, F.R.C.S.

An informal dinner was held at Oddenino's Imperial Restaurant, on Thursday, July 27th, to bid farewell to Mr. Joffe on the eve of his return to South Africa.

The dinner was a thorough success, though unfortunately Mr. Hughes, who had promised to be present, was prevented by illness from taking the chair. Al those present felt deeply how great a loss Mr. Joffe's departure will be to the hospital. The toast of his health and future prosperity was drunk with acclamation by all present. The success of the evening was greatly contributed to by the musical talent of Mr. Lansdown.

Notices.

Dental Department.

Applications are invited for the appointment of Registrar to the Dental Department for Children, duties commencing October 1st, and should be sent to the Treasurer, Superintendent's Office, not later than August 25th.

A. H. TODD,
Acting Superintendent.

Aug. 2nd, 1922.

Voices from the Past.

Ne forte credas interitura . . . .
Longe sonantem . . . .
Non ante vulgatas . . . .
Verba loquor. —Hor.

First Year's Men.

It was a few months after the Gazette celebrated its first birthday, that the son of my old friend, an Edinburgh man, came to Guy's. Of course I tried to make him feel at home in a strange place.

"Oh! I should like to see an operation, if I could! Could you take me to see one?" I glanced at the board and saw that they were just at that moment busy in the theatre. I thought for a moment whether it would be advisable, for, as I have said, the Operating Theatre is no place for first year's men. As he was, however, the son of a surgeon, I thought I would take the risk; so went with him on to the top benches. I was rather interested by what I saw on the table and forgot him. Presently, however, I heard a faint voice say, "I can't see; my sight has gone; take me out, take me out, or I shall faint." He was the colour of a chlorotic girl, a yellowish green. "I can't take you out," I said, "we are packed in. Sit down and put your head between your knees and you will feel better." He did so and kept murmuring in a faint voice, "Is it over? Let us go. Take me out, or I shall be sick. I can't see. Oh! I do feel bad."

The men courteously made way for us, and assisted me to get him down the steps and into the open air, where he slowly regained his colour and his equilibrium.

But it is a foolish thing for a junior man to waste his time and neglect his duties by getting in the way of senior men, in the wards and the theatre. Let them be content with the Surgery and O.-P. Room, when they want a change from the Dissecting Room; but if Gray and Ellis are anything like what they were when the Gazette was commencing to be familiar with "binders" and "leaders," he will not have much spare time to waste, but he will gradually and automatically get used to his new surroundings and become (if I may be allowed the pun) case-hardened.

Alfred Swayne Taylor.

It was felt keenly by the students when they had to mourn the loss of Alfred Swayne Taylor, the lecturer on Chemistry and Forensic Medicine. His lectures were most excellent. The long table in front of him was covered with bottles, glasses, slides, spectroscopes, etc., all of them illustrating and verifying the facts alluded to in his lecture. It was a great privilege to go down after the lecture and look at these things and have one's difficulties explained by such a wonderful teacher and genial a man as Taylor. He was one of the little band who won for our Hospital the fame and glory which went with the name of "Guy's." We little thought at the time, I am sure, of the enormous advantage we had over others in being taught by such men. Nothing seemed too much trouble. It always seemed such a pleasure to these great men to try and make the task of learning as easy and simple as possible to the student.

It is hard to realise now the high praise and glory which Taylor got, together with his colleague, Dr. Rees, in patiently and surely bringing home to Dr. Palmer the guilt of the Rugeley murders. It is considered clever now, when the steps and methods are familiar, but in those days the poisons were unknown and the methods of detecting them had all to be found out. However, they did it, and the country rang with their praise. These men taught the Guy's man of that day.

His Successors.

Debus, who succeeded Taylor, soon became popular as a teacher. He was appointed with Dr. Stevenson to take the Practical Chemistry Class, and the latter lost much in popularity by reason of his afoolness. One never felt he was in sympathy with the students. There was not that "fellow-feeling" which had always been such a strong feature in the Guy's men. "Give me a clean test tube," he would say when asked to assist in a "difficulty." One was offered. "I said a *clean* one," he would remark as he pointed to a finger smear on the outside. "When you have a clean one let me know." Of course one never had a clean one after that.

Debus was very genial, and so gained popularity. I have a pocket note-book now, in which he scrawled in chemical notation, the

various decompositions which took place in the formation of the compound salt under discussion. His big blue pencil made such big figures and letters that he could only get three or four lines on a page; the leaves were turned over so quickly and were so numerous that I feared my book would be at an end before the salt was properly formed.

"Botany" Lectures.

If I had the pencil of the recently buried "Spy," the caricaturist born of many generations of artists on both father and mother's sides, I could show by sketch better than by words the extraordinary scene which the Botany lecture presented at this time. The long table across the well of the theatre was covered with fresh gathered specimens illustrating the subjects of his lecture, and there, with his body bent at right angles over the table, was Johnson the lecturer, muttering in low tones his words, as he picked up the various bundles and handed them to the students, who used them for throwing at one one another, across the theatre, as long as the component parts held together. Johnson was deaf and blind to all this, but went on with his lecture till the hour was up, and the lecture ended, of which nine-tenths of the students had not heard a word. Yet in among that noisy rabble was one who took the Gold Medal in Botany of the Apothecaries' Society and is now the Professor of Forestry and Botany at Oxford University, and a great authority on his subjects—Sidney Howard Viner.

Dr. Debus.

There were at this period two teachers in Practical Chemistry. One class was under the late Dr. Thos. Stevenson, the other was controlled by Dr. Debus. He brought with him as assistant a typical German youth with curly hair and well-knit frame who wore a coffee-coloured velvet jacket, and went about with the air of an athlete. This youth looked a typical gymnast. But however great was his skill, or however numerous his virtues, he was not unconscious of any. He was fully alive to all his worth. In this large room the tables and benches were one behind the other, leaving only a narrow passage along the ends of the benches on one side. The backs of the benches, or rather counters and shelves for bottles, were high, so that no other men in the long room could be seen except those along one's own counter. My "stall" was on the very last bench at the end of the long room close to the door through which Debus used to bolt every now and then to his own private room. Dr. Debus spoke with a strong German accent, and I discovered that I could exactly imitate his voice and call out in the same "timbre." When he was at any of the stalls, helping any of the class, and wanted his assistant he would call out "Deer-r-ring!" "Yes, sir," responded Deering, and presently he came along peeping down the rows until he found Debus. I practised this call, until it was impossible to tell my voice from Debus's. It was impossible for anyone, except at our bench, to see when Debus popped through the door, either to go out or come in, so that everything was in proper order for my intended practical joke. So, one day, after a series of demonstrations, when he was no longer required, Debus had disappeared through his door, and Deering was busy with some student at the other end of the room, there resounded loudly through the room, "Deer-r-ring." "Yes, sir," came from the distance, and presently Deering would be seen peering down the long aisles of benches. At last he came to the last where my stall was. He looked perplexed. "Where is Dr. Debus?" he said. "Just gone to his room," was the reply. "I thought he called," said Deering. "So he did, but you were so long coming, he went away." "I came at once." "Did you? He looked pretty cross."

During all this time I kept a solemn silence. My part was to call out. It was for others to say that *they* had never called. Presently Deering went back. No sooner had he resumed his task than "Deer-r-ring" again rang out, in rather angry tones. Quick as lightning Deering rushed down the passage, peeping in at every row of benches, but there was no Debus. He could not understand it. "Where is Debus?" again he asked. "I don't know," some one said, "but he was calling you just now." Again he retired, looking somewhat vexed. Again "Deer-r-ring" was heard in loud tones. "Yes, sir," was the sullen response, and again he came peeping down the benches. This time he knew that the whole thing was a hoax, and he went back in a fury.

In a few seconds Debus came in again. "Will you come to my desk, sir," I said. He came. I had prepared a little problem which I calculated would require the services of Deering. I was right. There were only

empty bottles of the very re-agents he wanted. So as these had to be filled, he called out "Deer-r-ring."

"No, yer don't," was the reply heard in a mocking tone. Debus again quietly called out in his gentle voice "Deer-r-ring." "I'll come when I'm ready," was the answer. Debus was astonished, and again, this time loudly and angrily called, "Deer-r-ring." Presently, slowly and sullenly, Deering arrived with a storm cloud on his face, looking as though he was prepared to come to blows with anybody and everybody. When he saw the generally mild countenance of his master black with indignation, he nearly collapsed. "What you mean Deer-r-ring? Why don't you come at once when I call you?" "I beg yer pardon, sir, but I did not think it was you." "Take these bottles and fill them quickly, and next time I call you, come at once," said Debus. "Yes sir," was Deering's humble remark as he disappeared.

Again Debus stayed in the room, assisting and explaining to all who required his services. At last, being finished and having wiped off all his little "engagements," Deering's services being frequently summoned during his stay, he again disappeared through the door. His departure could be seen by us at the bottom bench alone. It was quite impossible for anyone higher up the room to know, unless they left their places and came and stood by us. No sooner had he gone than the call for "Deer-r-ring!" again rang through the room.

By this time the whole room was aware of some practical joke being played on Deering, and when again he came back from his fruitless enquiry, there was much badinage. I need not go on with a repetition of the old scenes. Suffice to say that Deering was brought nearly to despair, for he could never distinguish the two voices, and he never knew who his tormentor was. By and by he dropped a good deal of his swagger, and found that it did not pay to give himself airs. As he grew humbler and more deferential, he was forgiven the crime (for which he was not in the least responsible) of having supplanted his predecessor, Prior, who was a great favourite, and had been for many years a genial assistant in the Practical Chemistry Room.

The "Teaching at Guy's.

There is another point which I have observed which is a mark of the great teachers of Guy's to whom it has been my privilege to listen. That is, they gave you facts. Now, facts are always true. I am indebted to Dr. Braxton Hicks, Gynæcological Physician, fifty years ago, at Guy's, for drawing my attention to this. It is not an original observation. It may not have been even on his part, but it is one of wide meaning. If you can only enrich the Book of Knowledge by one additional fact, you have been a benefactor to your race. I would like any reader of this to note how much richer in knowledge he feels after he has listened to an hour's lecture of real hard true facts which he did not know before, and nicely prepared for his mental digestion: facts which will be as true in a hundred years as they are to-day. I would, I say, like him to compare this with a man of mere opinions on a subject. They may be right, or they may be wrong, but you cannot permit them to rank with facts. In any case they cannot make you a wise man or a better man than the speaker himself is.

Take as an example the little simple fact that Arago, the Astronomer Royal of France, imparted to Le Verrier, on his succeeding him. What was it? It was this. "I have observed a deflection in the orbit of Uranus at a certain point in its revolution; I advise you to watch it as it must be caused by some body beyond it." Le Verrier did so, and the discovery of Neptune was the result. It is true that Adami had noticed the same fact in his Observatory at Cambridge, but that is merely a supplementary detail. It is by building fact on fact, like stone on stone, that the Tower of Knowledge rises.

What Constitutes a Good Teacher.

I often marvelled at the easy manner that Wilks used to cram his bedside talks with facts. No wonder he turned out such practical men. He rarely gave his opinions except as a guide in deciding knotty points. Then it was more in putting a value on to the facts and evidence in the opposing scale pans. Estimating their relative weight as evidence.

Did you ever read the book written by Lord Penzance, the eminent judge, on the Shakespeare—Bacon question? I have read a good many by other writers, as well as his. All the others take one side or the other very warmly. They put great stress on things which favour their opinion, and cry down and make nothing of the evidence of weight on the other side. They are all strong partisans; all except Pen-

zance. You rise from their perusal in a very unsatisfactory state of mind; your mind is confused. Instead of deciding the point and leaving the question settled and clear, you are *more in doubt than ever.* Not so Penzance. He lays the facts before you; the reader is the jury. It is he who must decide. Penzance places all the evidence in a fair and equal light and estimates its strength and weakness, but never expresses his own opinion. When he has done this, and shown you what he reckons is the value of each item, he leaves you to form your own opinion. I never felt that I understood the case till I had read his book.

So with the science of medicine. Every day men are adding additional evidence. Only a trained, educated mind can sift these and separate the useful from the worthless, the grain from the chaff. This is better than a mere opinion on the whole case. It teaches you to think.

Guy's has always been noted for the excellence of its practical teachers. The art of teaching is a gift. It is like Music or Art, it comes from the unseen and descends on the individual in greater or less amount. It is not to be acquired by work. A man by patient effort may improve himself, but it is a divine gift. I have heard older men than myself speak of Addison, almost with reverence, as a teacher and eloquent speaker. I can speak personally of others, of whom I may sugggest Wilks as an example. He seemed to know the students' difficulties and puzzles. These he would analyse and put together again, till one could do it for onesself. He would go over the same ground, over and over again, in different directions until it was familiar. Gull, too, would put a difficult problem in so simple a way that almost any body could grasp it.

It is just the same with all subjects, School and College work; the teacher is the man who wraps up the parcel, or who prepares the matter in a way which he knows will be acceptable to the brain to digest. A man may be said to have a good memory, but this is only the faculty of labelling his stock and putting it in such handy places and pigeon holes of the mind that it is easy to lay the mental finger on it again when it is wanted. The name of a thing or fact is a handle by which we take hold of it. If the handle is not good we find, or make, one which is easy to grasp and recognise. All this is in the province of the teacher.

Wilks used to say that in giving a name to a disease or pathological condition, it is wise not to chose a word which implies a reason, condition or pathology, because that special view may, in time, be shown to be wrong, then the disease has to exist under a false name. It is best to use a word, he would say, such as "croup" which implies no meaning, and can be used with any pathology. See what confusion has been created in nomenclature by the use of the term "Rheumatic Gout" and its numerous polysyllabic progeny.

Some seem to me to appear to tear the leaf out of a book and pass it round, so that he who runs may read, if he likes. I have known public schools which have risen rapidly in public favour owing to one particular teacher. When he leaves, the success of the school diminishes. The other teachers are able and eager men, but they have not the gift. When I look back on my days of school, college, etc., I can recognize that my care for certain subjects was the earnest sympathetic way of the teacher of that subject. Brains in the scholar or student count, I know, but I am taking that as an average. It is in this one fact that a Guy's man can congratulate himself, and the GAZETTE can testify to it. It is the aim of the teaching staff to throw their hearts into their work.

A very popular book, one which used to be read in those far-off times as the leading work on medicine, was Sir Thos. Watson's Lectures. It was the experience of the lifetime of an able physician, and might be read with advantage even now by many well-educated young men of the present day on commencing practice. But compare it with the text-books now read by students when preparing for examinations. To put it broadly, it is Opinion against Fact; Empiric Conclusions against Scientific Proof; Philosophy against Science.

All men who have spent time at public school and college know that some of the very best and most distinguished scholars are poor teachers, I do not wish the reader to infer that the worst scholars make the best teachers, but, that teaching is a separate gift and has to be cultivated. Guy's has been lucky in having men who have recognised this.

FOOTBALL FIFTY OR SIXTY YEARS AGO.

About the time when the GAZETTE appeared, Football was in a very transitional state. Previously there were about as many ways of

playing as there were clubs. It was usual to play the two matches of the season according to the two different rules of the sides; one match under each rule. There were only two sets of rules which were widely recognised. One the Rugby, the other the non-Rugby. Even the Rugby Rules were played in two ways, but one even then was almost obsolete. Indeed, I never saw it played, but have heard it described by older men. These two methods were known as "hacking-over" and "hacking through."

As I have said, "hacking-through" was almost obsolete, although there were some who pretended to think it was the *only* game worth playing by men, and that the others were for children, girls' schools, and effeminates. Under this system when the ball lay on the ground and the player of one side tried to keep off his opponent by hacking his shins, then it was lawful for any player all "through" the field to hack the shins of any opponent he happened to be near. It was a cruel game and legs were often broken. I think there cannot now be any left who have ever seen it played. But "hacking-over" was common, although rapidly falling into disuse. In this game when two players met over the ball, instead of kicking, or trying to kick, the ball, the one would rush at the other and hack him off the ball. It has been seen where each would grasp the shoulders of the other and set to work on each other's shins until some other player took away the ball; then hacking must stop, for hacking was only permitted "over" the ball. Even this custom was giving way to the more humane rules of the "Association"; so that it was seen that the only way to ensure even the existence of the Rugby game was to drop the hacking entirely. This was done, and in a very short time the football world was either Rugby or Association.

In some the old method was allowed to continue, but it was only in very conservative schools and clubs that the obsolete game was allowed to linger. In all good matches in the late "sixties," it was, of necessity, either Rugby (non-hacking) or Association.

Guy's adopted the Association Rules early, and I remember, even in my time they had not become strictly codified, for the season began by the old fifteen playing double the number of new men.

It was a funny game. Forty-five men in the field. The thirty comprising one side being all strangers to one another, never having played together before. Some had never played the new Association rules and the rest varied often in detail of method.

The young and growing Association had much to overcome in the way of satire and scorn. By many it was dubbed "handball,"* not football. In my schooldays the mark of a good player was the "drop kick." A man who could be relied on to make a good "drop-kick" was sure to be selected for a team. I remember in the sixties when I played in the opening match at Guy's I caught the ball, made my heel-mark and then sent it spinning away with, what I thought was, a splendid drop-kick. Up came our captain, W. H. Jalland, late of York, "What did you do that for?" he said; "What else could I have done?" I said with some resentment. "You should have run with it," he replied. "Handball," I muttered. We were always forbidden to touch the ball by the hand, as it stopped the game, and gave the opposite side a free kick, the only exceptions being the goal-keeper and "a catch."

In these new Association Rules it seemed all handling and running.* There was no skill of feet required. All that was wanted was long arms and long legs. Skill with the feet was of no advantage. In fact, the feet were not required except in running. In the old non-Rugby game, which the new Association Rules almost entirely superseded, a good player was a man who could drop-kick and "dribble" well. That is, by the skilful way of managing his feet, take the ball before him through the ranks of the opponents, then at the proper moment, when more dribbling became impossible, "pass" it by a well-timed kick to another of his own side more favourably situated. Another point was a good "charger." This was to run full-butt against the man who was "dribbling" and take the ball from him. Often a colleague would run beside the man who was dribbling to keep off "chargers," and so defend the ball. I have very often seen a good charger send both these sprawling yards away, and capture the ball with his feet and go off with it himself. All this required great skill and practice. A man who was solid, muscle and bone, not fat, made a good charger. A light man was at a great disadvantage, for

*[The Association of those days seems to have been more like our present Rugby game. ED.].

in charging a heavy man he would rebound off like a ball, and being charged would go down like a feather, and seeming to the charger to offer no resistance. It is a novel sensation for a man say of 10 stone, but looking only 9 stone, to charge a thin man of 7 or 8 stone; the contact is hardly felt. He is seen to go flying off without being touched.

Widdowson, who afterwards took such a leading position in the athletic world, and a man who afterwards entered Guy's, were the two best chargers and footballers in the club to which they both belonged. Widdowson was a sturdy, stiff-built youth, but only a moderately fast runner, and therefore of no special merit in the Association game, but as a "non-Association" or "Rugger," he was just what was wanted. I don't suppose any of the present generation are old enough to remember his name, but his renown was great in the seventies. His wind was perfect, and he was one of the best long-distance runners.

But the rules of football have for many years now been formulated and settled, but when first the GAZETTE made its appearance, even then the term "football" had a diversity of meanings, and by many the Association Rules were thought specially suited for delicate children and young ladies' academies.

UNWRITTEN LAWS.

There was a little incident in the Surgery which impressed itself on my memory. It was important as showing the wisdom of some unwritten laws.

I had just come down from the wards and was talking to the dresser for the week, who was not endowed with either too much knowledge or manners, when a man was led into the Surgery by two other men. "This man looks bad," I said, "we had better see to him." "Oh! it is only a scalp wound; he came yesterday," said the dresser. "Why didn't you take him in then, yesterday, he looks bad enough?" I said. "If I took in every scalp wound that came, I should have soon nothing else in my beds," said the dresser in somewhat questionable taste; to which I replied, "In this case ,at any rate, I insist on you taking him in." The man was taken in and died the next day. He was found to have a fracture of the base of the skull.

There was an inquest, of course, and as H.-S. I had to appear and bear the full blame of not having recognised his injury when he first came up. Evidence showed that the wound was caused by a fall on the pavement on being turned out of a public-house. I was astonished at the array of legal gentlemen present. One appeared for the landlord, one for the man who put him out, for it was a question whether he fell down, being so drunk he could not stand; or was he thrown down by unnecessary violence being used. I was cross-examined severely on his being sent away on his first visit to the hospital. Why was he sent away?—Because it seemed the right thing to do. Do you think it was right?—If it had not been right it would not have been done. "Would he have stood a better chance of recovery if he had not been sent rattling over the stones of London backwards and forwards in a cab, as was done?" "That is a question of probability, which I decline to answer," I said, for I knew that a medical witness is not only bound, like a common witness, to speak as to facts, but also, as a scientific witness, to give his opinion on those facts, but I was not bound to give an opinion on probabilities. This point saved me, otherwise I might have been brought in as an accessory to manslaughter. The dresser was really to blame, but it was an understood fact that the H.S. bore all the responsibility. Hence that useful rule—In all cases of doubtful scalp wounds, always consult the house-surgeon. The dresser was here again distinctly to blame. He had clearly broken two of the old standing unwritten laws of Guy's. In all cases of doubt, and especially scalp wounds, call the H.-S. He got severely "wigged" by his fellow-dressers who felt his folly was a disgrace to all and calculated to lower the tone of the office.

THE ACCIDENT WARD.

A year or two before this, when the GAZETTE was in an embryonic state, there were three interesting cases in Accident Ward at the same time. One was a Finn sailor, very fat and with immense limbs, who had fallen from the top of the mast on to the deck of the ship. The captain said the height from which he fell was 60 feet. His only injury was a simple fracture of the thigh. In the next bed was a man who had fallen down the two bottom steps of a flight of stairs. He had fractured his spine and in a few days died. Opposite to them was an engine driver, who had fallen from a locomotive whilst in motion; his leg lay across the rail and the wheel of the engine went over it. The tibia was crushed to fine powder by the flange of the wheel, but the

piece of bone that lay across the metal remained whole. It was a horrible looking wound. The surgeon very properly advised amputation. The man refused. It was urged upon him, otherwise gangrene would set in and probably kill him. "I don't care if it does," the man said, "I would sooner die than have my leg cut off." "Very well, then," replied the surgeon, "I refuse to take the responsibility. I will leave you to my dresser."

The dresser asked the H.-S. to give chloroform and thoroughly cleaned out all the debris and got the mangled parts into the best possible state. He then firmly fixed the lower and foot so that there should not be the least movement. Absolute rest and careful cleanliness, as far as this was understood in those days, were so far effectual that the man eventually made a good recovery, and beyond about an inch of shortening was none the worse for his terrible crushing. This was a remarkable result in those days, as was shown by the surgeon in charge of the case giving a clinical lecture on it, and saying, "I am proud of the case and of my dresser."

The District Around Guy's.

The district around Guy's included then some of the worst slums and most dangerous areas in London. Amongst these I think Kent Street and Mint Street bore the palm. Kent Street was the best known of these and was a still backwater in which gathered the vilest and most degraded types of humanity; but if I had to select what might be called the most dangerous area, I should unhesitatingly choose Mint Street. Kent Street is quite familiar to all Guy's men who live in the neighbourhood of Trinity Square, for it lies between there and the hospital. Mint Street ran from the High Street exactly opposite Newcomen Street to Southwark Bridge Road, where the Evelina Hospital stands. When I was Registrar at the Evelina it was a short cut then to go along Mint Street. Like Kent Street there was nothing specially noticeable about it, except that it never looked awake. The shops all had their shutters up, the doors of the houses were all shut, there were no people about, but stalwart policemen paraded up and down in pairs. It was during one's "extern" period that one saw these places properly and understood the reason of their ill-fame.

Some five and twenty years ago I was exploring some of the remembered places in the Boro., and amongst others sought Mint Street. But it had gone. I think I knew Mint Street, in its day, as thoroughly as an extern could know it. For during the six weeks it took me to attend my 100 cases, I think I must have visited some part of Mint Street every day. It was not the street itself, but the slums behind the street, and I never saw anywhere else such long tortuous alleys and deep hidden squares and long blind passages leading to nowhere but another square or quad, even still more remote from any sign of what may be called one's fellow-creatures or respectable humanity. In these buried solitudes, if a man could only be beguiled into them, it would be useless to cry out or call for help. I have known, to a certain extent, other haunts of crime such as the East End, Seven Dials, New Cut, Clare Market, and other dangerous places, but in none of them was there such a large area of stagnant dwellings in squares and yards, through which flowed no stream of life other than the occupiers of these crowded houses.

I have seen a good deal of these places and the people who live in them, and I was struck by the comparative fewness of the men. The houses were let off in rooms, and each room crowded. Even the cellars had occupants. I wonder if such things as I sometimes saw are still existent.

One case I attended was in a cellar, a damp, cold, underground chamber, absolutely void of any furniture. The "bed" was a bundle of straw, clean for the occasion, thrown in a corner. I had to give a neighbour sixpence wherewith to wrap the expected infant. There were no clothes or accessories such as towels.

In another instance the patient had got the loan of articles for the bed and herself, but there was absolutely nothing for the baby. As the moment of its advent drew nearer and nearer, I urged them to try and get something to wrap it in, for it was a cold winter night and there was not a rag of any description in which to receive it.

Neighbours kept coming in to see how we were getting on, but none could think of any article to wrap round the new arrival. I suggested taking a sheet or blanket off the bed, but was told that these were on loan. I asked the other women if they had not got something in their wardrobes. One and all said they had not. Their entire stock of napery and clothing

was what they each one stood up in. I have no knowledge of what preparations had been made for clothing the child, that did not concern me, but I did feel it my duty to try my utmost to get something to put round the new born in this fireless room on a bitterly cold winter night. It was useless. At last I announced, "It is here, you must get something, even if it's only an old newspaper." The three neighbours looked at each other in blank astonishment when they heard the first faint whimper from under the bedclothes, but there was nothing so far to keep it warm. "Can you not get something?" I said at last in despair. "It is a cold night for a new-born child to lie naked on a wet bed." The warm motherly heart of one of the three poor women could not bear to see this shivering mite, so, suddenly saying, "I'll take off my flannel and chance it," she whipped up her skirt and took off the only petticoat she had on; perhaps, and probably, the only one she had in the world, and wrapped it round her neighbour's child. How is this for charity?

(To be continued.)

Reviews.

The Student's Pocket Prescriber and Guide to Prescription Writing. By D. M. Macdonald, M.D., F.R.C.P.E. Seventh edition. (Edinburgh: E. & S. Livingstone.) Price 3s. net.

The sixth edition of this little book was thoroughly revised and altered to include all changes associated with the British Pharmacopœia of 1914. This latest edition is a reprint of the previous one with the exception of various errors which have been corrected.

The introduction contains information as to the method of prescription writing and the compounding of medicines. There is also an extremely useful section on "Some Points in Prescribing," dealing with the more common errors, and a special one on "Incompatibilities," which often prove a stumbling block to the unwary.

The main bulk of the book consists of an alphabetical arrangement of the various systematic diseases. Under these headings are the prescriptions to be used in each respective case, together with occasional notes on the specific use of certain drugs with their most suitable therapeutic value.

The addition of posological tables for both adults and children, together with an appendix of weights, measures, abbreviations and a vocabulary, make this little volume an extremely useful guide and companion to all students and practitioners.

Taylor's Practice of Medicine. Twelfth Edition. By E. P. Poulton, M.A., M.D., F.R.C.P., with the assistance of C. P. Symonds. M.A., M.D., F.R.C.P., and H. W. Barber, M.A., M.D., F.R.C.P. (London: J. & A. Churchill.) Price 30s. net.

It is surely a remarkable achievement to present, in one text-book, a comprehensive and detailed account of the whole of medicine. Dr. E. P. Poulton has, however, effected this in the latest edition of Taylor's "Medicine," which he has thoroughly revised and brought up to date. Recognising that one mind is not enough to deal with so vast a subject, he has ably succeeded, without breaking the continuity of the book, in obtaining the collaboration of Dr. C. P. Symonds, who has compiled the section on Nervous Diseases, and of Dr. H. W. Barber, who is responsible for the account of Skin Affections.

The changes in this volume are considerable, and there are few articles to which new material has not been added, many being rewritten, so great have been the recent advances in medicine. In addition to some twenty-five entirely new articles there are now twenty-four plates instead of twelve, nineteen of these being new. Four of the plates are sections of the Spinal Cord, the remaining twenty being radiograms, care being taken in the selection of appearances which are commonly met with.

In addition to dealing with the section on Nervous Diseases, Dr. C. P. Symonds has written the article on Encephalitis Lethargica, which appears amongst the infectious diseases. The articles on Tropical Diseases have been revised, and in many cases rewritten, by Dr. J. J. Conybeare.

Changes have also been made in the classification. Diseases of Metabolism are dealt with in the same section as diseases of the Ductless Glands, and there is a separate section on diseases due to deficiencies in diet.

An excellent feature, from the student's point of view, is the extremely clear and lucid instructions for clinical investigations of the blood, urine, etc., and also the detailed accounts of examinations of the chest, abdomen, and nervous system. These precede each respective section.

We can sincerely recommend the volume to all students and practitioners as the best English text-book on medicine, and we heartily congratulate Dr. Poulton and his collaborators on their achievement.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Nurses' Lawn Tennis.

FINAL OF THE "NURSING TIMES" INTER-HOSPITAL COMPETITION.

The Guy's team, by beating the St. Marylebone Hospital in the semi-final of the "Nursing Times" Competition, qualified to meet the London Hospital in the final. This Final Tie took place at St. Marylebone Hospital on July 28th, and, as was anticipated, a very keen struggle was witnessed before the Guy's Nurses were able to gain the victory.

According to the rules of the competition, each Hospital enters two teams, an A and a B team, and in the event of one Hospital winning the A match and losing the B match, the Cup goes to the side which wins the greatest number of games. It was only by the narrow margin of two games that Guy's eventually won.

"A" MATCH.

In the "A" match Sister Point and Sister Scotland of London opposed Nurse V. Stubbs and Sister W. Johnson of Guy's. In spite of some good volleying by Sister Point, the Guy's pair won the first set pretty easily by 6–3. In the second set Nurse Stubbs began by losing her service game, but by steady play the Guy's pair, both volleying well at times, brought the score to 4–1. The London pair now made a great effort, Sister Scotland playing an especially reliable game, and eventually, after a tough fight, won the set by 8–6. In the third set the Guy's pair played very well, Nurse Stubbs bringing off some good volleys, and playing a steadier game than in the previous sets. Sistor Johnson won many points by her well placed returns. This set was won by Guy's, the score being 6–3. Guy's thus won the "A" match by 6–3, 6–8, and 6–3.

"B" MATCH.

In the "B" match Nurse Vian and Nurse D. Stubbs of Guy's opposed Sister Rutherford and Sister Kinder of the London.

Guy's lost the first set by 6–3. Nurse D. Stubbs played a very sound game, with an attractive style. Her net play was very good indeed and won many points for Guy's. As a result of this most of the returns went to Nurse Vian, who played a steady base-line game, doing all that was required of her at first. Unfortunately the excellence and persistence of the London pair wore down Nurse Vian's resistance, while Nurse Stubbs lost a few points unnecessarily by mis-hitting. London won the second set also by 6–3, and thus the match. The third set had to be played in order to decide who was the victor in the competition, and Guy's were faced with the difficult task of beating an apparently superior pair by at least three games if they were to be victorious.

This feat they accomplished. The last set indeed was the most exciting of the day. The Guy's pair led at first by 2–0. The London team then drew level, but the Guy's pair now proved too much for them. Nurse Vian played a strong game, while Nurse Stubbs, still serving and volleying well, proved much more reliable in her returns than in the previous two sets. Guy's won this set by 6-2 after a hard contest.

The Guy's teams are to be congratulated upon their success in defeating the holders of the Cup, and we commend in particular the fine rally of the "B" team in the last set of the tournament.

Nurses' Swimming Club.

The Nurses held their Annual Sports on Wednesday, July 26th, 1922, and a most enjoyable evening was spent. A varied programme was arranged and many Nurses entered for the different events. The Baths looked very gay with flags and decorations, and the evening's success was greatly added to by the efforts of the Jazz Band. Lady Fripp and her two daughters were present, and Nurse Garland presented Lady Fripp with a bouquet on her arrival. Miss Daly, of the Bath Club, kindly acted as starter and judge.

The two items of special interest were:—(1) A very splendid exhibition of swimming and diving by the Misses Betty and Venetia Fripp, which was thoroughly appreciated by the large crowd present. Their swimming is really wonderful, (2) The competition for the Silver Challenge Cup presented by Lady Fripp. Twelve Nurses entered for this, and they were marked in diving, breast stroke, side stroke and floating, Nurse Garland, the holder of the cup for 1921, was again successful, gaining 30 marks out of a maximum of 40. Nurse Cornwall was second with 24½ marks.

Other events were:—(1) One length Flat Race, won by Nurse Ellen Young. (2) Team Race, Nurses versus Massage Students, won by the Nurses. (3) Diving for Plates, won by Nurse Ellen Young. (4) Two lengths Flat Race, won by Nurse D. G. James. (5) Back Race, won by Nurse Cornwall. (6) Beginners Race, won by Nurse S. A. Davies. The last item on the programme, Musical Hoops, was a variation on "Musical Chairs," specially suited to water, and this concluded the evening's performance.

Lady Fripp then presented the Challenge Cup for Swimming, which she so kindly gave to the Swimming Section in 1921, to be competed for each year; competition is keen, as the winner holds the Cup for a year. Lady Fripp also gave a few words of encouragement to the Nurses, remarking on the great improvement shown since last year. She also presented the prizes given by the Matron, each winner being heartily cheered.

The Matron then thanked Lady Fripp and Miss Daly for all they had done to help the Nurses, and the Misses Fripp for their exhibition. She pointed out how fortunate the Nurses were to have such interest taken in their sports. The guests then departed amidst very hearty cheers from the Nurses, aided by the music of the Jazz Band.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

TO a vast number of people in the world outside our confines, Guy's Hospital is renowned mainly for its high standard in all branches of sport. This alone, however, does not constitute true greatness. The fundamental object of a medical school is to apply the arts not only of learning, but also of teaching, in such a way as to attain the highest possible standard in medical education. This is a duty to mankind, and towards its fulfilment the energies not only of teachers, but also of students should be directed. To pass examinations is not necessarily to be a learned man, but we can say with some truth that a pass list is evidence of the successful methods of education in a medical school. A glance at the list of successes in the July examinations (published on pages 342-3) should bring a feeling of pride to all who take an interest in Guy's. It is a monument to the energy of all who co-operate in the work of the hospital.

Much has been said of the unit system of education which was recently imported from America. It was stated that this system would revolutionise medical education, and already it has gained a firm foothold in some of the London hospitals. But to our mind success cannot be attained by mere changes in methods and administration, however novel they may be. We have read in "Voices from the Past" how excellent was the teaching and education in the bygone days of our hospital. The personality of one great teacher or another towers over those around him, and in years to come many of the present generation of students will look back on those at whose feet they sat and learnt, and perhaps will pick out one or two and attempt to distinguish them from the rest. But through all the ages we have based our successes on something deeper—the wonderful co-operation and good feeling that exists between the teachers and those who learn from them. It is the maintenance of this close co-operation in the true spirit that will ensure us many successes in the future.

The members of the Staff and the students alike are to be congratulated on so fine a result of their work. It would be invidious to pick out names from amongst so many successful candidates, but we would offer our sincerest congratulations particularly to Mr. Gaymer Jones, who not only passed the Final F.R.C.S. in the earlier part of July, but was also the only candidate to obtain the London M.S. in the same month.

It is not generally known how heavy is the work incurred in the compilation of the Clubs' Union Year Book. This work is now in hand, and notices have been issued to all Secretaries of the Constituent Clubs asking them to send in accounts of the activities of their various Clubs and Societies. In many cases, however, there has been an unusual delay with a consequent increase of the difficulties in the compilation. We feel sure that the respective Secretaries will do all they can to lighten the work in this direction and will send in their reports as soon as possible.

S. N. Stubbs. N. Stubbs.
Sister Johnson. S. N. Vian.
Guy's Hospital Nurses' Lawn Tennis Team.
Winners of the *Nursing Times* Challenge Cup.

From time to time we receive correspondence and contributions from anonymous persons. Far be it from us to discourage any contributor, either big or small, but we feel compelled to draw the attention of these mysterious beings to a small notice which appears on page 343. This states that contributions must be accompanied by the writer's name and address, *not necessarily for publication*.

We publish on pages 354-5 particulars of some Foreign Tours for Students which are being arranged by the National Union of Students. For some time past the medicals in the London hospitals have been taking up a broader outlook and have entered in some part into the social and athletic life of the University together with the other Colleges. Already the University Union Society has been housed in a building of its own, which will shortly be opened as a club for the use of members, and slowly but surely the medicals are coming in to take their part in the progress of what will eventually become the largest Union Society of its kind in England.

The National Union of Students is undertaking affairs from the still wider national standpoint. The Oxford and Cambridge Union Societies have already joined the Union, and every University in the country is now represented. Co-operation is also being obtained, through the medium of the Union, between the Universities of England and those of Scotland, Wales and Ireland.

Internationally the Union has made it possible for the students of this country to take an active part in matters affecting students throughout Europe. This Easter a delegation was sent to Leipzig, and did yeoman work in the matter of exchanging visits between students of different countries, correspondence, etc. It is in this way that the Union has, with the conjunction of student organisations in other countries, been enabled to arrange an excellent series of European tours for English students at reasonable rates.

To travel in a foreign country is an education in itself, and no student should ever miss the opportunity if it comes his way. If only we could get to know and understand those with whom we have lately been in conflict much can be done to promote real peace in the world. This reason alone should be conducive to travel. But for medical students the National Union has provided a more immediate incentive in the special arrangements which can be made to visit foreign hospitals and to study their methods. We wish the Union every success in its bold ventures.

"If Summer Comes." No, this is not the title of a new novel shortly to be issued by our harassed Editor. It merely expresses the hopes of many dejected mortals for a slight change in the weather. In spite of this, however, our attentions are once more being diverted from cricket and tennis to the coming football season. Mr. S. P. Meacock, who well deserved his re-election to office, has been anything but idle. An excellent list of fixtures for the Rugby Football Club has already been arranged, and no one should lose the opportunity of investing a shilling in a fixture card as soon as these are issued. In addition to repetitions of many of last year's matches there will be one or two new home fixtures, such as that with Aberavon. We can see that the Rugby Fifteen will have a hard season in front of them, but we feel sure that under the able leadership of Mr. P. K. Albertijn they will continue to raise the high standard and immortal traditions of Guy's Rugby.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Old Time Football.

SIR,—Your interesting correspondent in "Voices from the Past," is hardly correct in stating that the "hacking over" game ceased in the "early Sixties." I remember it well in the middle Seventies at Rugby. I was at a preparatory school there as a small boy. We played this barbarous game then, but we did not do much harm with it. In the "scrums" there was a good deal of close kicking, but my recollection is that boys dodged "hacks" as well as gave them. At the "big school," on the other hand, as an on-looker, I have heard players roar with pain from hacks, and have heard the click of boot meeting bone, some distance off. If a player was running with the ball, the cry used to go up "hack him over." Instead of trying to collar him an opponent would run at him and try to kick him on the ankle and thus disable him with pain. Along side of this "hacking over" at football there was a horrible method of fighting at Rugby in those days, call "Downing." This consisted of two boys standing opposite one another and at a given signal hacking at each other's shins until, from sheer pain, one of them gave in! I believe the origin of this form of combat was that it left no visible sign of an encounter, and thus avoided punishment by the school authorities, to which ordinary "fisticuff" performers were liable. I remember a boy showing me his boots which he had had "sharpened" at the toe end of the soles preparatory to a "down." As a result of "hacking over" or "downing," I never heard of a broken leg, or even of a septic wound in these days before antiseptics.—Yours faithfully,

FREDERIC VICARS, M.D.

Wimbledon.
August 8th, 1922.

Rupture of Uterus through Cæsarean Scar.

DEAR SIR,—I can record a case of this condition still earlier than Mr. Swan. Like him I must trust to memory.

During my term as Obstetric Resident in November or December, 1892, a dwarf of low mental capacity was sent up and admitted into Dorcas Ward, under Dr. Horrocks. She was near full term and brought a history of having had Cæsarean section performed a year previously at St. Bartholomew's. Dr. Horrocks remembered that the case had been reported to the Obstetrical Society, of which he was then Secretary, and found the details in the M.S. Transactions, which he was preparing for publication.

The appearance of the abdomen was striking; the walls very thin and pendulous and a kind of pouch, like a miniature elephant's trunk overhanging the pubes. At the most dependent point was an ulcer of the size of a shilling, and at the operation this was found to be very near perforation.

On opening the abdomen the child (dead) was seen to lie partly inside and partly outside the uterus, the head having escaped through the old scar. A curious feature of the case was that both fallopian tubes had been ligatured at the first operation and now one (the left, I think), was found to be divided with a space of half an inch between the ends and in the other the ligature was still in situ.

Dr. Horrocks removed the uterus and remarked that she had had Cæsarean section twice, but he would guarantee that she did not have it a third time. Two days afterwards she was shouting for "pudden" at dinner time and made an uneventful recovery,—I am, Sir, yours truly,

R. L. WASON.

1, South Side,
Clevedon.
August 9th, 1922.

Two Cases of Von Recklinghausen's Disease.

During the last twenty years only eight cases of Von Recklinghausen's disease have been admitted to this Hospital, and of these, two came in with other complaints, the multiple tumours being found secondarily during the course of examination.

The explanation of this lies in the absence of pain and disability; indeed it is often only by accident that the patient discovers that he has the lumps although they may have been present for many years.

Pain then is usually absent, but there are exceptions to the rule as will be seen by the cases of two sisters suffering from this complaint who were recently in the wards at the same time, one on the surgical side, under Mr. Trethowan, the other on the medical side, under the late Clinicals.

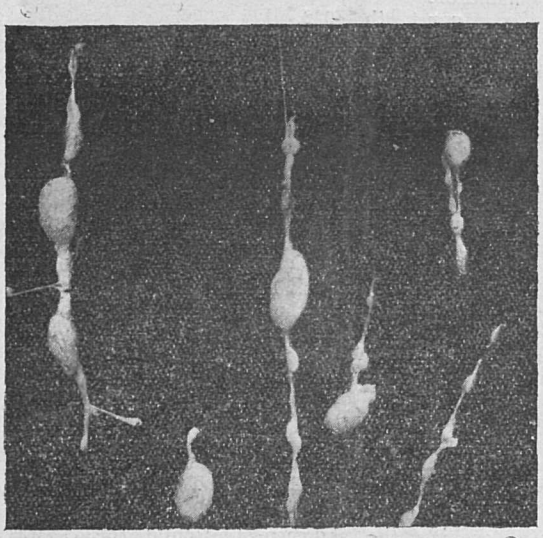


Photo by G. A. Walker.

Multiple Nerve Tumours removed by operation from the case of Von Recklinghausen's Disease.

W. B.—The surgical case, a female, æt. 29, unmarried, was admitted for painful swellings all over the body. She had had the complaint ever since she could remember, but the tumours were painless until eleven years ago, although she could never bear her arm being pinched or being dried with a towel.

When eighteen years of age she was operated on, a large tumour over the right shoulder being removed. In the following October a second tumour was removed from the right leg. She then had an interval free from pain for six years, after which the tumours became painful again and she had them removed from time to time; having eleven operations in all.

Three years ago the patient was kicked by a horse on the left arm, after which a tumour commenced to grow in the anticubital fossa becoming very painful and of great size. In the February following the accident Mr. Trethowan operated and incised the mass. It was found to be too large to remove, the whole of the median and ulnar nerves being involved in the neoplasm.

Family History.—Her father died of Addison's disease at the age of 31 years. Her sister was thought to have Addison's disease, her grandfather on the mother's side died of diabetes, and three uncles on the father's side all died before 33 years of age, one of Von Recklinghausen's disease.

History of the present condition.—A year ago the patient noticed a swelling on the back of the knee which has grown steadily larger and is now very painful. It was to have this removed that she came into the Hospital.

Condition on admission.—The girl is bright and very intelligent. She has a dark complexion, her body is deeply pigmented all over, the pigmentation being most marked on the axillæ and groins. She cannot lie on her back because of tender swellings and so is addicted to the morphia habit. Without morphia she is never free from pain. For a year her appetite has been bad, she often vomits three to four times a day, gets easily tired and easily out of breath. Since admission she has vomited frequently, the time of vomiting having no relation to the time of taking food.

Alimentary system.—Teeth good, tonsils and fauces clean. There is slight tenderness on palpation over the left iliac fossa, but she is very constipated. Her lips show herpes.

Cardio Vascular System.—The pulse is regular heart normal. Blood examination shows a relative and absolute lymphocytosis and decrease in polymorphs. HC 80%, red corpuscles 4,000,500 per cmm., whites 16,000 per cmm.; blood pressure diastolic 75 mm. Hg, systolic 80 mm. Hg. Temperature 99; pulse 80; respiration 20; respiratory and urogenital systems normal.

Nervous System.—Her cerebration is very good and the cranial nerves are normal. The sensory nerves throughout the body, with the exception of the face are involved in tender, painful, globular, subcutaneous swellings ranging in size from a small pea to a marble, and situated at short intervals throughout their distribution. Thus along the auriculo temporal nerve a chain of nodules can be palpated. On the popliteal nerve is a mass the size of an orange. The motor nerves do not seem

to be affected. There is no obvious change in the tactile, thermal, or deep sensibility. Reflexes are normal.

Mr. Trethowan operated and removed a large mass from the popliteal space, measuring 4 cm. by 2½ cm., roughly spindle shaped and involving both internal and external popliteal nerves. A number of chains of swellings were also removed from the buttocks and anterior abdominal wall. Pathological examination showed the excised tumours to be specimens of neurofibromatosis.

Mabel B.—The medical case, aged 31, female, was admitted for epigastric pain, vomiting and weakness. Her skin had been dark ever since birth, but during the last few months she noticed that her colour was becoming darker. Six years ago small pigmented spots appeared on the trunk. She was born in England and has never been abroad. At eight years of age she had peritonitis (? TB), and at 28 years of age her appendix was removed, when old adhesions between the intestines were found. She has never menstruated.

History of present disease.—Ten years ago she had a pain in the epigastrium immediately after taking food. She sometimes vomited, this, however, did not relieve the pain. The attack would last for two or three weeks then there would be an interval of freedom lasting some weeks or months. When in an attack she could only take milk diet. This condition of affairs has recently been aggravated. At times she has to give up her work on account of the pains. She has lost weight and become weaker during the last year or two.

Condition on admission.—Pulse 92; temperature 97; respiration 20; her skin is of uniform dark colour, but on the trunk, shoulders, and upper part of the thighs, are small areas of deeper pigmentation. There are a number of small painful tender, globular, subcutaneous nodules in the abdominal wall, inner side of the thigh, and left pectoral region. Her features are those of a Hindu.

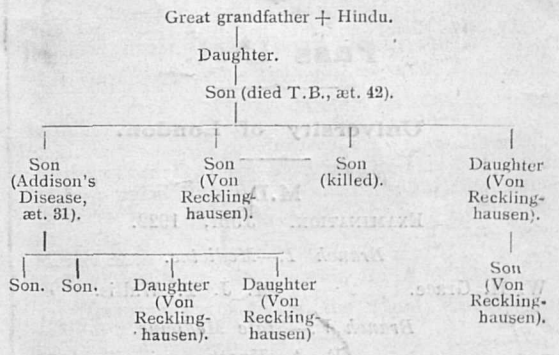
Respiratory System.—A few crackling rules were heard on auscultation over the right apex and there was some impairment of air entry on this side. X-ray examination of the chest showed the presence of a number of large glands on the right side.

Alimentary System.—Teeth showed marked pyorrhœa, the tongue is clean, pharynx normal. The abdomen is retracted and liver, spleen, and kidney not palpable. There is some general tenderness in the umbilical region. Fractional test meal is normal. Bismuth and X-ray show a normally placid, but slightly atonic stomach.

Cardio Vascular System.—Normal; pulse rythm, irregular; Blood pressure diastolic 85 mm. Hg, systolic 95mm. Hg.

Nervous System.—The pupils react to light and accommodation and the cranial nerves and reflexes are normal. There is slight muscular weakness in the right leg. The tumours are again limited to sensory nerves although there is no disturbance of sensation. There is no pigmentation in the mouth. The diagnosis rests between Addison's disease and tuberculosis, associated with neurofibromatosis.

Some additional facts relating to the family history of these two girls was obtained later from the relatives. They date the commencement of the disorder to the marriage of the great grandfather to a Hindu. By this union there was one daughter whose son died of tuberculosis, aged 42. He had three sons and a daughter. The eldest son, the father of the present patients, died of Addison's disease. The second son was killed in an accident. The daughter had Von Recklinghausen's disease, which was transmitted to her son the cousin of the present patients. In the present family, besides the two daughters suffering from Von Recklinghausen's disease, there are two sons free from the complaint. The following table will help to make these points clear:—



The interest in these two cases lies in the consideration of the differential diagnosis. That both had Von Recklinghausen's disease inherited through at least three generations there is no doubt. The marked pigmentation in each case, could be put down to the pigmentation which normally accompanies neurofibromatosis, except that it was rather more generalised and diffuse than that associated with this condition. Or it could be traced to an abnormal origin through the Hindu ancestor, for, as Sir Arthur Keith has shown, the suprarenal gland is directly concerned with the laying down of pigment in the body. A disturbance of suprarenal function in the offspring of the Hindu and white man could then account for the generalised pigmentation, it could also account for the Addison's disease of the father. On the other hand the Addison's disease in the father may have been due to tuberculosis. It has been noticed that each of these girls had vomiting, weakness, wasting, pig-

mentation and a low blood pressure, and in both cases the diagnosis of Addison's disease could be made. Points against this are the fact that both subjects have been confined to bed for some time, which would tend to lower the blood pressure, and cause weakness, or, as an alternative, the family history of tuberculosis through the grandfather, and the presence of tuberculous signs in the second case could account for the vomiting, wasting, weakness, and pigmentation; although the other sister showed no signs of tuberculosis. The pigmentation was deeper and more marked than is usually found in tuberculosis although it could well be accounted for by the Hindu ancestry, apart altogether from disease. The conclusion arrived at was that these subjects were suffering from neurofibromatosis, associated with a condition presenting all the symptoms and signs of Addison's disease. There is in the Museum of the Royal College a specimen of neurofibromatosis, the subject from which the tumours were taken having died of Addison's disease. If, however, the conditions are associated it must be a very rare occurrence. R. B.

Pass List.

University of London.

M.D.

EXAMINATION. JULY, 1922.

Branch I.—Medicine.

W. H. Grace. M. J. T. Wallis.

Branch V.—State Medicine.

F. A. Knott.

M.S..

EXAMINATION. JULY, 1922.

J. Gaymer Jones, F.R.C.S.

1st M.B. Examination.

JULY, 1922.

T. G. Benjamin.
R. C. Brock.
E. D. Y. Grasby.
M. L. Hutchinson.
A. B. Hyman.
S. C. H. Lane.
C. W. Marshall.
L. G. J. Pitt-Payne.
T. Mc. K. Robb.
J. W. Schabort.
A. Signaiewsky.
N. H. Skelton-Browne.
J. R. C. Spicer.
W. R. C. Spicer.
S. E. Theis.
S. R. Trick.
F. S. Warner.
J. G. Weston.
M. K. Young.

2nd M.B. Examination. Part I.

Organic Chemistry.

JULY, 1922.

C. E. Allen.
P. Berry.
D. G. Bown.
S. Chazen.
E. T. Clifton.
H. W. D. Crook.
C. W. Marshall.
J. D. Rear.
E. H. Roche.
E. S. Rudaizky.
W. D. Sheldrake.
S. D. H. D. Wallis.
J. K. G. Way.
L. S. Williams.

2nd M.B. Examination. Part II.

Anatomy, Physiology and Pharmacology.

JULY, 1922.

L. Bechal.
S. Berman.
R. N. Brandwood.
A. A. Dalby.
D. F. Durward.
M. E. M. Jago.
J. G. Kingsbury.
F. H. K. Knight.
R. G. Nethery.
J. N. D. O'Rafferty.
H. L. Peake.
A. W. Riddolls.
J. Sellick.
D. A. Skan.
H. H. Steadman.
J. D. S. Thomas.
W. S. Whimster.
H. K. Williams.
C. L. Worthington.

Conjoint Board.

FIRST EXAMINATION. JULY, 1922.

Chemistry and Physics.

A. McEwen.
K. H. Wright.
*S. F. Williamson.
†L. Brown.
*C. C. F. White.
*H. S. Marks.
M. T. Brockman.
M. Shaw.
†G. G. Cameron.
*R. Maneschewitz.

*Physics only. †Chemistry only.

FIRST EXAMINATION. JULY, 1922.

Biology.

G. H. Greenway.
R. Maneschewitz
N. H. C. Allen.
J. D. Cambrook.
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E. E. Graham.
L. A. Steel.
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A. E. Maclagan.
C. E. P. Parry.
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SECOND EXAMINATION. PART I.

Anatomy and Physiology.

D. R. Martin.
B. E. Hawkins.
T. St. H. Silvester.
F. A. Wilson.
J. R. Ratcliffe.
L. Rhys Jones.
F. Widlake.
T. I. Williams.
E. G. Smallbone.
H. Trafford.
O. H. M. Woodridge.
D. H. Couch.
P. C. Cumber.
D. C. Drake.
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C. L. Froehlich.
A. E. Hill.
H. Van der Post.
R. H. El Sawy.
H. E. Filmer.
S. M. Reeders.
A. C. Taylor.
R. A. Norman.
*E. Bowen-Jones.
W. K. Targett.
V. L. Fisher.

SECOND EXAMINATION. PART II.

Pharmacology and Materia Medica.

B. E. Hawkins.
W. K. Targett.
H. K. Wallace.
H. M. Worth.
N. A. Arnold.
I. M. Hurwitz.
J. M. Van Schalkwijk.
C. J. V. Dobbin.
R. C. May.
C. W. Warne.
G. S. Landon.
S. Cieman.
E. H. J. Berry.

FINAL EXAMINATION. JULY, 1922.

Medicine.

*M. M. Hegab.
*D. A. Windemer.
C. L. Kark.
H. W. Harvey.
*H. W. Taylor.
*H. Richards.
H. A. H. Harris.
*C. M. Short.
F. J. Biddle.
G. B. Kirkland.
*H. K. Wallace.
G. C. W. Curson.
A. Farid.
*L. H. B. Macleod.

Surgery.

*H. Richards.
*C. M. Short.
*H. K. Wallace.
V. R. de Boissiere.
I. J. Bechal.
H. C. Meathiel,
W. G. R. Hore.
D. G. Sharp.
*J. S. Hudson.
*W. M. Ramsden.
*R. Hale-White.

Midwifery.

M. Markiles.
H. A. H. Harris.
H. G. R. Canning.
R. J. Hooker.
V. R. de Boissiere.
H. C. Meathrel.
S. S. Suzman.
G. E. Fisher.
J. L. Woodhouse.
S. C. Bakhle.
E. Orsmond.
L. Forman.
C. O. Carson.
P. Hack.
W. G. Booth.
D. B. Whitlock.
G. R. M. Apsey.
A. F. Percy.
P. G. Harvey.
P. G. Sedgwick.
H. Evans.

*Have now completed the Examination.

Royal College of Surgeons.

L.D.S.

FINAL EXAMINATION. JUNE, 1922.

Part I.

W. O. Bailey.
H. J. Walters.
J. S. Dick.
H. Slater.
A. M. Nodine.
P. K. Albertijn.
T. G. Edwards.
A. E. Nelson.
R. Schlimmer.
S. T. Hine.
E. L. Sprong.
W. J. Williams.
G. Zondagh.
I. M. Zondagh.
J. R. Palfrey.
E. A. J. Bradley.
J. E. H. Duckworth.
G. T. Hankey.
L. B. Helder.
F. G. Hutchinson.

Part II.

V. St. J. Alexander.
J. F. Allin.
C. V. T. Baugh.
N. S. Campbell.
J. H. R. Creasy.
B. Crisp.
I. S. de V. du Toit.
J. C. Faure.
T. F. Fox.
A. V. Goodson.
W. J. Hide.
J. V. Human.
E. J. Joels.
E. M. D. Mackie.
A. A. R. Madgwick.
G. M. Mew.
F. A. Meyer.
H. F. Miles.
B. R. Moore.
H. Radin.
M. Rubenstein.
H. G. Ryder.
C. P. C. Sargent.
H. V. R. Sellers.
K. G. Sharvill.
G. L. Shearer.
D. J. Stofberg.
V. L. Sunderland.
L. N. Theron.
R. Van Geuns.

PRELIMINARY SCIENCE EXAMINATION. JULY, 1922.

C. B. Boyd.
M. Farwell.
D. Guré.
C. M. Ross.
*C. W. Siddle.
*F. A. J. Zettel.
A. G. Taylor.
V. W. L. Wells.
†K. F. Pedley.
†E. N. Stevens.
†I. A. Barlow.
*G. G. Grainger.
*R. C. Lillicrop.
*R. N. Winnett.
*De W. Vorster.

*Physics only. †Chemistry only.

L.S.A.

FINAL EXAMINATION. JUNE, 1922.

Medicine.

*H. Amin.

Surgery.

*C. A. Marais.

FINAL EXAMINATION. JULY, 1922.

Surgery.

C. F. Parry.
*W. H. A. Pratt.

*Have now completed the Final Examinations.

L.S.A.

PRIMARY EXAMINATION.

Materia Medica and Pharmacy.

J. Totton.

Anatomy and Physiology.

J. Dywien.
R. H. El Sawy.
T. McD. Kellough.

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Pleural Empyema.

CLINICAL LECTURE BY C. H. FAGGE, M.S., F.R.C.S.

GENTLEMEN,—There are many subjects we study which seem to overlap medicine on the one side and surgery on the other, and perhaps because they do not belong solely to one or the other of the different divisions of our craft, they are apt either to be overlooked or to be paid undue attention to by both physicians and surgeons.

It seems to me that empyema is one of the conditions which has been, as far as my knowledge goes, ignored in clinical lectures in recent years by both parties.

The causation of suppuration in the pleura may be summarised under the headings which I have written up, viz. :—

1. Pneumococcal—extension from the lung, or through the blood stream.

2. Secondary to infections below the diaphragm—from a subphrenic abscess or liver abscess (usually on the right).

3. Pyæmic—secondary to acute osteomyelitis.

4. Tuberculous—secondary to a primary focus in the lungs, mediastinal glands, or ribs.

5. Infective process in the lung—septic pneumonia, gangrene, growth, or hydatid.

6. Traumatic, especially after penetrating wounds, when it follows acute pleurisy or hæmothorax.

The first is a condition which we are quite ready to expect when working in the medical wards, but are often inclined to forget that it may be met with in the surgical wards as a complication of post-operative pneumonia. It is generally assumed that the infection spreads direct from the lung to the pleural cavity, though there is no reason why an empyema should not arise as a secondary manifestation of a pneumococcal infection through the blood stream, just as other secondary infections may occur, not necessarily in the chest—pneumococcal peritonitis will serve as an example.

The second class is, perhaps, that which most often gives rise to difficulties in the surgical wards: such an empyema secondary to infection below the diaphragm is nearly always on the right side. We are so often exercised over the question as to whether there is a collection of fluid above the diaphragm in cases of acute appendicitis, perforation of an ulcer of the duodenum or stomach—a subphrenic abscess being an intermediate factor in all cases.

Thirdly, there is the most interesting surgical disease we meet with in childhood—acute osteomyelitis of the long bones, in which an empyema may arise as a pyæmic manifestation.

We have at last begun to realise the importance, in relation to treatment and prognosis, of the recognition of the particular organism which is the active factor in the various types of this disease. Whereas in the first class the pneumococcus is usually assumed to be present, it is by no means uncommon to find other organisms in such cases, the pneumococcus having died out in the presence of a more virulent secondary organism (this must be very rare) or the original organism having been of another kind. The organisms which give rise to the second class may be very varied indeed. Among these bacillus coli, intestinal streptococci, bacillus proteus and many others will be met with.

In empyema secondary to osteomyelitis, staphylococcus aureus is almost constant, the same organism causing the empyema, as is found in the primary infection.

In the fifth class I have attempted to include those infections spreading from the lung to the pleura which are not due to the pneumococcus or to the tubercle bacillus. The pathology of these cases is, of course, varied, organisms which can be carried into the lung in inspiration predominating, but I have no knowledge which would give us any help as to their relative importance in prognosis and treatment.

In the surgical wards we usually meet with this type of case when an abscess in the lung due to inhalation of a foreign body ruptures directly into the pleural cavity. When the pleural cavity is involved by a penetrating wound with or without a compound fracture of the ribs, such as often occurs in a gunshot wound of the chest, the organism which usually flourishes in a traumatic hæmothorax or serous effusion is the streptococcus longus.

None of the above conditions exercise any preference for either side of the body, except those which come under the second heading,

and in these—acute appendicitis, perforation of a duodenal ulcer, etc., involvement of the right pleura is obviously far more common than of the left, probably in the same proportion as that by which right subphrenic abscesses exceed those on the left side.

The path by which infections above the diaphragm follow those below it is not perfectly clear. Whether there are in the diaphragm lymph tracts which have been called "pseudostomata," and which allow the passage of organisms from below to above the diaphragm, is still undecided. If such paths exist, it is, perhaps, hard to understand why such lymphatic infection only takes place from below upwards, and never from above downwards, as we know that in other lymph tracts the path of infection is not necessarily always in one direction.

I have very little doubt in my own mind that the paths by which infection spreads from the lower to the upper surface of the diaphragm is nearly always microscopic. There is no gross perforation of the diaphragm, and so the expression that a subphrenic abscess has ruptured into the chest is inaccurate pathologically. Again, I should like to suggest to you that infection does not extend through the diaphragm during the acute stage of the initial abdominal lesion. Such a process takes time, and I do not recall having seen such an infection within two weeks, at the shortest, of an acute abdominal emergency. I attempt to emphasise this point because I want you to conclude that evidence of septic infection occurring in the first two or three weeks must not be attributed to infection of the pleural cavity through the diaphragm, but is rather due to an embolic pneumonia or a gravitation pelvic abscess.

I cannot pretend, of course, to give you an expert opinion on the physical signs to which the presence of pus in the pleural cavity give rise, but I feel very strongly that even as a surgeon I should not ignore them, as I feel it is the duty of a surgeon to acquire a practical knowledge of such matters. I hold that none of us can afford to pose as a surgeon or physician exclusively. A good physician must have considerable surgical knowledge, and any man will be a much worse surgeon than he otherwise would be if he knows no medicine. It is very difficult for a surgeon to estimate the value of an expert opinion by a physician on any chest condition, unless he can verify for himself the signs on which this opinion is based. This is particularly true in the present day, when the surgery of the chest is becoming more and more a practical question.

When pus is present in the pleural cavity, inspection will show defective movements of the chest, possibly bulging of the intercostal spaces, with œdema occasionally, usually associated with tenderness on palpation. Tactile vocal fremitus will be reduced or absent, with diminished resonance or dulness on percussion, and diminished or absent voice sounds on auscultation. The curious change in the voice sounds, which is called aegophony, often associated with scodaic resonance over the same area, must be looked for when it is suspected that the empyema only partly fills the pleural cavity. Of all these signs, it may be that we rely most on dulness to percussion, and here it must not be forgotten that when a portion of lung intervenes between the chest wall and the collection of pus, as in an interlobar empyema, dulness may be absent. Similarly, when gas-producing organisms infect an empyema, the area of the chest involved may be resonant.

I have purposely omitted one very characteristic sign which may be seen or felt when there is an empyema, and that is, displacement of the heart-beat. This sign has been, in my experience, of most value in obscure cases on the right side, and I wish to draw your attention for a moment to a question which has puzzled me considerably in cases where one knew there was a collection of pus below the diaphragm, and it is whether such a collection can displace the apex-beat, or whether such displacement of the apex-beat must definitely indicate an effusion above the diaphragm. Personally I think there is no doubt that the latter view is correct, and I think the apex-beat can be displaced only by an effusion above the diaphragm, but I should be very glad of any clinical evidence in opposition to my dogmatic statement, because it is a clinical sign which it has puzzled me to interpret on several occasions.

Mode of Onset.

It is often extremely difficult to determine with moderate exactitude the onset of suppuration in the pleural cavity, but at times this is sudden and heralded by certain characteristic symptoms. Thus, a patient who has had up

to that moment an apparently harmless hæmothorax of moderate degree from a gunshot wound, has a rigor which subsequent events will show to have been the first sign of infection. Again, a patient who is judged to be holding his own with some infection below the right side of the diaphragm may have a rigor or a sudden rise in respiration rate, or possibly temporary dyspnœa and slight cyanosis draw attention to his chest. As pus accumulates in the chest the patient sweats, becomes more pale, loses flesh and appetite, which signs, when associated with an unfavourable estimation of his clinical progress generally, must surely point to some focus of infection which is beginning to declare itself, and which it must be our immediate purpose to discover.

It is obvious that as most empyemata are secondary to other inflammatory conditions in which there usually is a leucocytosis, an estimation of the leucocyte count or even a rise in the percentage of the polymorphs is rarely of any value as evidence of the presence of pus in the pleura. Again, whereas it is obvious that in some cases one can get valuable evidence from an X-ray which will show a diminution of the movement of the right side of the diaphragm or an opacity in the chest, it is just that patient in whom such evidence is particularly wanted who is too ill for such a method of investigation except with a portable X-ray.* In reference to the absence of mobility of the diaphragm it must be borne in mind that any inflammatory condition below the right dome may give rise to it.

Prognosis.

Before we enter upon the thorny question of the correct treatment of an empyema, let us briefly consider the outlook of the patient under expectant treatment. What will happen to the collection of pus in the pleura, if it is left alone? It may point on the chest wall, and if it does this, we are told that it usually does so outside the breast in the axilla. I must confess that I have never seen this, though, for teaching purposes, I have often warned you of its possibility. In any case, this is not a termination to be desired, but on the other hand, an empyema may, and not infrequently does, rupture into the lung or into other organs in the chest and abdomen. The latter I have never seen, and conclude that the statement made in text-books in reference to the rupture of the empyema into the œsophagus or stomach must refer to the happenings of the past, and need scarcely be considered or legislated for at the present time. I feel very strongly that the rupture of an empyema into the lung is an unfortunate event which adds considerably to the difficulties of the surgeon, for, as far as my experience goes, and I believe I am expressing a general opinion, spontaneous cure of an empyema by rupture into the lung is exceedingly improbable, and as infection of the air passages is likely to ensue if this method of drainage is not relieved by a better one, it is, in my opinion, a definite indication for surgical intervention. Now it is obvious that it is more difficult to locate a cavity half full of pus than one which is distended, and as such an empyema communicating with the lung is sure to contain air as well as pus, the difficulty of its localisation in increased, because the physical signs are likely to be misleading.

The establishment of external drainage by rib-resection in cases where the empyema has ruptured into the lung has, in my experience, always led to a cessation of expectoration of pus within a few days, and to a satisfactory healing of the external sinus : I have not met with a fistulous communication between the bronchus and the chest wall. Such, I conclude, is more likely to occur if surgical intervention is delayed, and the inference is obvious.

I have just said that the coughing up of an empyema is unlikely to lead to spontaneous cure, but I recall that when I was a clinical, a young man was in John with an empyema which we failed to locate, and he coughed it up. The late Mr. Dunn was called in, and to the best of my recollection the patient's chest was explored with a needle on several occasions without locating the empyema. We tried to let the collection accumulate so that we might explore under the most favourable circumstances, but he always coughed up the pus a day or two before we were going to needle him again. Now, for many years after this event this man was potman at the "Grapes," in St. Thomas's Street, and when I lived there I often spoke to him, so that I know he was perfectly well for many years.

* The writer is much indebted to help from the portable X-ray outfit of the College of Ambulance.

Situations.

It is obvious that the remarks I have made about physical signs and their interpretation apply particularly to parietal empyemata. The displacement of the heart, mediastina, and lung will naturally vary with the position and amount of the pleural effusion, but, as a general rule, the lung is displaced towards the hilum and backwards.

Now the second variety of empyema (that secondary to infection below the diaphragm) is particularly likely to be diaphragmatic, and there is no reason why examples of any of the others should not be interlobar. A diaphragmatic empyema causes much difficulty in diagnosis, and I have reason to believe that interlobar empyema is more common than is generally held, for several times when operating on what was regarded as an abscess of the lung, I have found either then or at the post-mortem, that the condition was really one of interlobar empyema.

Differential Diagnosis.

It is so often a difficult question as to whether continued irregular pyrexia for some time after a definite attack of pneumonia is due to an unresolved pneumonia or to a secondary empyema. This question is particularly likely to arise when we have to deal, not with a typical eight-day pneumonia ending in a crisis which is usually caused by the pneumococcus, but with those cases which are atypical in their course, and which I believe are often met with in influenza epidemics. The type of pyrexia may be persistent; a spikey chart, with a temperature falling to normal in the morning and rising to 102° in the evening, being in favour of pus rather than of solid lung. It is easy to argue that physical signs will clear up the difficulty, but mistakes frequently happen and consolidation of the lung may be associated with an inflammatory effusion below the diaphragm, particularly when such collections are of the size to which subphrenic abscesses often attain.

The importance of differentiating between a pleural effusion and an empyema is not so great, because in either case the value of putting in a needle to settle the question amply repays the discomfort to the patient in so doing. I am afraid the conclusion of the whole matter, as far as differential diagnosis is concerned, is, to my thinking, simply put in the words, "When in doubt, explore," and when I say this, I mean explore at the very earliest moment of your doubt, for it is the only method by which one can be sure of the presence of pus, and also be sure of the localisation of that pus.

Solely on the interpretation of the physical signs, it is often difficult to determine whether the pus is above or below the diaphragm. A needle introduced through the chest wall into a subphrenic collection will be seen to move with the movements of the diaphragm. This, which is known as Furbringer's sign, is often of value, even though as in most of such cases the respiratory movements are limited.

I must confess that I have often resected a rib, introduced my fingers into the abscess cavity, and even then failed to be certain as to whether the collection was above or below the diaphragm. Help may be gained by the realisation of the fact that there is a limit beyond which the diaphragm cannot be pushed upwards, but such a limit is extreme, and while I doubt if pus aspirated through the fifth intercostal space could be below the diaphragm, it is in those cases in which the seventh or eighth rib is resected that this point is of so much difficulty and importance.

Now the whole object of my lecture to-day is to impress upon you the importance of the early use of the exploring syringe. I had so many examples of it during the war, that I shall never forget the lesson I learnt then, and I cannot too strongly impress upon you or too often repeat to you the advice, "When in doubt, explore," for there are, I feel sure, no pathognomonic signs of solid lung, any more than there is a definite sign or symptom which excludes the presence of pus in the pleural cavity. Obviously the only sensible way to treat an empyema is to treat it like an abscess anywhere else, namely, to evacuate the pus at the earliest possible moment. You must not allow your patient to remain with his abscess undrained until the man in the street can tell you that it is present. Of course the needling of the chest must be done at discretion. Often it is almost certain that there is a collection of fluid in the chest, and you only want to know its nature and its bacteriology. This is a second and only less important piece of information which can be obtained only by aspiration.

Now, in such cases you are justified in needling the chest in one place without an anæsthetic, and, if desired, and the pus is not too thick, as much as possible may be drawn away through a long tube by gravity, but in the difficult and obscure cases, exploration without an anæsthetic may be inconclusive and should not be employed more than once. In such cases, after a preliminary injection of scopolamine and morphia, the patient is laid flat on his back, or turned with his sound side uppermost, and given gas and oxygen, when the needle is introduced in a routine manner into the spaces where physical signs suggest the possibility of pus. Thus, it may be necessary to needle in the posterior scapular line, in the axilla, and again in the front in three or four spaces, and to the full length of the needle in every instance. In fact, the method to be employed for the discovery of pus above the diaphragm is that which the late Mr. Barnard many years ago advised should be used for the localisation of subphrenic abscesses. It may be argued that such a proceeding is utterly unnecessary, and so it is in nine out of ten cases, but it is in the tenth case that such a methodical proceeding gives us valuable information which cannot be obtained by any other means. Until recently I should have said that no harm could result from this being done, but during the last few months I lost a patient within a few hours of being needled in this way for a suspected empyema which the post-mortem showed not to be present.

[NOTE.—It is a strange stroke of fortune that since this lecture was delivered I should have had to assist in carrying out such a methodical search for pus in one of my own children. There was every evidence of pus, possibly above but probably below the diaphragm, following acute appendicitis. The physician could find no definite signs, and a needle had been inserted some ten or twelve times before the collection was struck in the front of the right chest, which subsequent drainage showed to be due to a gas-producing intestinal streptococcus, so that the resonance over this area was accounted for.]

Treatment.

I have tried to insist that evacuation of an empyema must never be delayed, but having said this, I am not at all certain as to the best method of carrying it out. If the preliminary exploration can be done with a fairly large needle there is much benefit in allowing as much pus as possible to drain through a long, fine tube, for this proceeding when the collection is a large one will allow the thoracic contents to adjust themselves to altered mechanical conditions before the rib-resection is undertaken. It is obvious that this is particularly true in small children in whom, relatively speaking, any empyema is a large one. Now the present tendency is to repeat such aspiration, and not, as we have usually done in the past, to resort to rib-resection within twenty-four hours. At present we have scarcely any definite indications as to the cases which can be treated by repeated aspiration. In some pneumococcal empyemata, the pus is so thick and curdy that it will not escape through a needle of ordinary size, but I feel that there can be no harm in making at least two attempts to empty the chest by this method, which I believe is in the future going to supersede rib-resection in many cases. The question is one of selection of the right kind of case, and probably this will be determined on a bacteriological basis, hence the importance of a preliminary aspiration for the purpose of identifying the organism present, and clearly aspiration is applicable for early rather than for late cases. It must be understood that we are only discussing drainage of the chest when the effusion is frankly pus, for the question at issue—aspiration versus rib-resection—cannot apply to any cases in which there is a serous effusion, even if freely mixed with blood, for in this, aspiration alone must be entertained unless and until pus is present. I am inclined to think that repeated aspirations will be particularly useful in cases of tuberculous empyema which do badly after rib-resection, and in those cases of empyema following effusions below the diaphragm in which the pus is often very thin, and is frequently mixed with air. There can be no doubt that the treatment of empyema by a drainage tube will ultimately disappear, for one of the fundamental principles which has been established by chest surgery during the war is that closing the chest after any operation is the one thing that makes for safety. I am sure the successful thoracic surgeon of the future will be the man who closes the chest as often as he can, and takes risks in that direction rather than the man who is always draining for safety.

When aspiration is employed, it can best be done by fitting a long tube on to the end of

a hollow exploring needle. The other end of the tube is placed under the surface of an antiseptic fluid in a bottle on the floor, and so the the contents of the pleura are evacuated by gravity, but in some cases it may be necessary to start this process by suction with a large syringe. Carried out in this way the process is more gradual, less painful, less dangerous, in that it does not, like sudden aspiration with Potain's apparatus, interfere with the mechanics of the thorax, and it does not tend to replace the fluid by blood effusion from the lung surface. When aspiration fails, owing to the thickness of the exudate and cannot be carried out, rib-resection must be resorted to, and also it must be a procedure of choice when cases of some duration have to be dealt with, for it must be regretfully admitted that even now cases come to the hospital in which pus has undoubtedly been in the chest for several weeks. For these, no further time must be wasted by efforts at aspiration. It is only in the last thirty years that resection of a rib has replaced drainage through an intercostal space, and we should be proud of the fact that this method was introduced into this country by Sir Arbuthnot Lane.

Now it is quite unnecessary for me to discuss in detail the performance of the operation of rib-resection for empyema, for in technique it has altered very little since first introduced, but recently there has been an interesting discussion in the medical press as to the most favourable place for drainage. At first sight it appears to be a very simple question, to which the answer is—at the most dependent spot. But even then we shall soon realise that it is not entirely to the patient's benefit to lie on or lean against a drainage tube, for with the patient sitting up in bed the most dependent spot is at the back.

We shall have further to modify our decision when we come to consider how the lung expands in order to obliterate the cavity from which the pus has been evacuated. If we watch the lung expand immediately after good drainage is given to a recent empyema, you will see that it at once comes to the surface all round the periphery of the abscess cavity, but that it does so less and less completely as the centre of the superficial circle is reached. From this fact one may conclude that the last portion of the cavity to be filled up is the centre, where the cavity is deepest, and that if we wish to make the best use of drainage, this is the spot in which the tube should be inserted. It is quite obvious that the position of the tube must vary with the position and size of the cavity in every individual case, so that there can be no one position in which the empyema should be drained. As far as possible, to my thinking, one should resect at least two inches of rib in the centre of the superficial area of the empyema, or rather below this. When possible it should be done where the chest wall is thin, and any position in which the tube is likely to be an inconvenience to the patient should be avoided.

There are two or three points in connection with this apparently simple operation that I should like to draw your attention to. In my opinion the patient should never be turned over on to his sound side. If it is possible, owing to location of the pus, to resect a rib in the axilla, the patient may be pushed to the edge of the table for that purpose, but it may even be necessary to turn him on one side, and when it is, it must be to the three-quarters prone position with the sound side uppermost. This should be a rule without exception.

Secondly, the only real advance in the treatment of empyemata in recent years is the use of a long tube, which must be of sufficient bore according to the consistency of the pus to allow it to escape freely. It is secured by sutures through the skin and tube, so that one end just projects into the pleural cavity, the other is carried into a Winchester quart on the floor, and so arranged that its open end is always under the surface of the fluid. This tube, which may have a small hole near its end, but, of course, no other, is left in as may be necessary from four to ten days.

Whenever the dressings are being changed, or the fluid in the bottle under the bed is being renewed, the tube is clamped so that no air may get up the tube into the pleural cavity. By this means we attempt to assist expansion of the lung from the first by maintaining its negative pressure. When there is only an ounce or two of fluid in 24 hours going into the bottle, the sutures retaining the tube are cut, and the tube completely removed, care being taken that no air enters the sinus while this is being done.

[NOTE.—In the last case treated by this method the tube was removed on the fourth day, and the wound was healed within seven

days of the operation, from which day the temperature came down to and remained at normal.]

In arriving at a decision as to when it is safe to remove the tube, my view would be, when in doubt, remove it, for I feel very strongly that it cannot be removed too soon.

At the end of 1918 the course of a bilateral empyema emphasised the value of this line of treatment. The one side was drained by the old method with a short tube, and it did not heal for months; the other, which developed later, was drained with a long tube, and healed within a few weeks and has given no further trouble, whereas a modified decortication has been necessary on the side first operated upon. Mention of this patient reminds me that when both pleural cavities are simultaneously involved, resection should be done on one side only, and the other should be aspirated. When possible it is better to aspirate both, but as far as my experience goes no evil results from draining both pleural cavities, provided an interval of a few days is allowed to elapse between the operations. I have not had much experience of bilateral empyemata, but as far as I recollect all have done well.

For the chronic empyemata the best treatment is prevention, in other words, early recognition of the presence of pus, immediate aspiration and drainage by rib-resection as soon as it is clear that aspiration is ineffectual. Of the methods which have been advocated recently for the treatment of this condition I cannot believe that irrigation of a pyothorax with antiseptics can have much influence on its healing. Again, I have nothing favourable to say for the use of Bier's cup; if the empyema is properly drained Bier's cup is unnecessary. When I have had to use it I have found it both painful and useless. In those cases where a suppurating track or cavity has remained after an empyema in civil life, or in connection with some wound of the chest, I have abandoned all other operative measures in favour of a modification of decortication as introduced by Fowler and Delorme. A suitable rib, usually about the fifth (the site of the former operation will generally be found too low) is widely resected, and the gap opened out with a Duval's rib-spreader. The organised exudate upon the lung is then removed. In some cases that from the parietes may also be stripped up. As a general rule, it is unnecessary to remove either the visceral or parietal exudate completely, for provided the adhesions of the lung at the circumference of the septic cavity to the thoracic parietes are made absolutely free, the expansion of the lung will take place though decortication of the lung involved or free incisions of the exudate must assist it. It can be shown that one only removes organised exudate from the pleural surfaces, for after the lung has been dealt with its surface is smooth, and the alveoli are not opened up. The chest is then closed without drainage. It may be one of the most heroic and interesting operations in surgery, and in my experience has never failed to obliterate the septic cavity.

Voices from the Past.

Ne forte credas interitura . . . .
Longe sonantem . . . .
Non ante vulgatas . . . .
Verba loquor. —Hor.

(Continued.)

What sort of odour is wafted up to heaven from an act of self-sacrifice like this? How does it compare with the charity of the fashionable lady who drops a shilling into the church plate from her well-filled purse on Sunday?

When I got back to the rooms and told the men of the affair it made such an impression, and the old woman's self-denial sank so deeply into their hearts, that for many a day after that her words became a catch phrase, and no man would start on a venture or incur any risk without marking his resolve by saying, "I'll take off my flannel and chance it." It was synonymous with, "I'll risk it."

In one or two of the houses even in these slums sufficient might be noticed to show indications of cleanliness and tidyness. The husband of one case fetched me, and as he passed through one bedroom to get to the patient's, he pointed proudly to six little forms fast asleep in one bed—three lying transversely on the lower half and three longitudinally with their heads on the pillows. If still alive, those six little heads would be old men and women now.

In some houses in Bermondsey, then let off as single room tenements, I noticed moulded ceilings and ornamentation showing that in bygone days it had been a fashionable quarter.

The Assistant in the Museum lived in the row of houses off Maze Pond, a few doors from the "Ship and Shovel" public house. He took in students as lodgers. The lodgings were much in request as they were clean and very quiet. When I lived there the land between them and London Bridge Station was not built upon, but they were just beginning to put in the foundations of what was afterwards MacCorquodale's Printing Works. As I said the neighbourhood was very quiet, only the slight rumble from St. Thomas's Street disturbed the stillness. But one afternoon as a friend and myself sat reading there was the unusual sound of the yelling a pig makes when it is being killed. We wondered we had never heard it before, but there was no doubt about it then. It was not distressingly loud, for it sounded too far away, but its long continuance so far aroused our curiosity that we decided to go and investigate. There had been time enough to kill a hundred pigs, but the noise was as shrill as ever. We had not to go far. Outside the "Ship and Shovel" sat a woman, the centre of a knot of onlookers. Her eyes were closed, teeth clenched and her hair dishevelled. Her dress was unbuttoned at the neck and thrown open from the chest. Her head and neck were bent backwards. Each hand and arm was held by a policeman, stretched at right angles to its full length. Women were holding burnt feathers and smelling bottles to her nose, while she in the meantime kept up her continuous scream. It was a striking picture.

In the centre a rigid, yelling woman, neck and chest all bare, arms widely extended and each firmly held by a burly policeman. "Fetch me a quart pot of cold water," I said to an onlooking barman. He was soon back with it, and calling out, "Stand aside or you will get wet," I dashed it full on her bare chest and neck.

The shock made her gasp for a second or two, but she soon resumed her music. The policemen shook the water from their coats and again held on. As to the woman she was saturated, for the water not only splashed upwards over her neck and face, but ran in streams under her clothing. It was November and a bitterly cold day, but there was nothing else to do but persevere. "Fetch another," I said, and the quart of water was soon again in my hands. Although the woman's eyes were shut and she was apparently entirely engrossed with her own melody, no sooner had I got the second pot into my hands and was about to drench her a second time than she snatched her hands from the grasp of the policemen, and, dragging her wet clothing over her exposed thorax, jumped up quickly from the chair and hurried away.

I would like to compare this incident with another one, something similar. It was a strange co-incidence that early one morning I was just finishing a tracheotomy in Miriam Ward when the H.P. came in great haste to fetch me to do the same operation on a patient in Mary. Hastily leaving others to finish the dressing of the operation I had just done, I hurried off with the H.P. to the top of the new building. The patient, an adult woman, was fortunately still breathing. Presently her quiet respirations stopped and the chest walls did not move. There was no struggling or excitement, she simply lay breathless. "Do you wish me to open her windpipe," I said. He replied, "I don't know what to do; she can't go on like this; but she isn't blue. I can't make out why she isn't blue. Yes, I think you had better do it." I quickly laid her head back and put her in proper position, but no sooner did I take the knife in my hand than she began to show signs of inspiration. "Stop, stop," cried the H.P., "she is breathing; don't cut." I withdrew my hand, and the patient gradually resumed breathing. "What a time she lay without any air, and yet she never turned blue," said H.P.

Presently again she began to choke and soon once more her respiration ceased entirely. Again we waited, the H.P. at last in despair telling me to open the trachea. The events happened exactly as before. I need not recite each fact, for one was the same as the other. However long we waited there was apparently no respiration, the H.P. constantly repeating, "She doesn't turn blue, I can't understand it. Look at her lips; they're not blue," until fearing the effect of this long apnœa, he would again request me to begin. This happened four or five times. Each time as soon as ever the knife approached the skin there would be a gasping effort, and again the H.P. would call me off. At last I said to him, "Will you be kind enough to make up your mind whether you want me to open this woman's windpipe or not? If you wish it done let us do it and

be done with it; but if you don't wish it, I will go back to bed."

"I don't know what to do" he said, "I'll ask Fagge." So presently in came the Junior Assistant Physician muffled up in scarf and top coat, for it was a bleak cold morning. As he approached the bed she was lying quite motionless, like one dead, no movement, no breathing. One glance was enough. "Put a bucket of cold water over her" he said, and turned on his heel and went off.

His instructions were carried out to the letter. A bucket of cold water was brought and the helpless woman's chest and shoulders dragged off the bed over an empty tin. Her hips rested on the bed and a nurse supported the exposed head and shoulders. I poured the bucketful of cold water over her bare shoulders and chest. Breathing commenced and she opened her eyes for the first time. The bucket was again filled and kept ready near her bed, but she had no more relapses. H.-P. and I went back to our beds; his last words as we parted were, "I can't make it out why she didn't turn blue."

Hysteria.

In my opinion these two cases, taken together, gives us help in understanding hysteria. There have been many definitions of hysteria, each one different, yet each one true to a certain extent. It depends much on the standpoint from which the view is taken. A schoolmaster showed a small boy a ring and asked him what shape it was. "Round," said the boy. To another he showed a penny and asked for the shape. "Round," was the reply. To the next he showed a globe and again enquired the shape. "Round," was the answer.

In this same way do the definitions of hysteria meet the question. They describe it more or less, but do not meet all aspects. Sir James Paget condensed the whole into a paralysis of the will power. He said the patient is the victim of her own neurosis. It is a nerve storm which overpowers the harmony of her nervous system. Her intellect is controlled entirely by her emotions, instead of her emotions being controlled by intellect. Looked at in this light he summed up the whole condition into, "It is not that she will not will, but she cannot will." For the general run of hysterical conditions this is a pretty accurate view to take. No set picture ever truly represents a thing that is never the same two minutes together. No written form of words can describe a series of combinations that are never twice alike.

Compare his definition with these two cases I have quoted. Do they verify his words? No. What do they demonstrate? They show that both the women were under the influence of a violent emotion, one noisy, the other placid. The emotion was one of pleasure, for they were willing to keep it up indefinitely until it brought something unpleasant in its train, then, and only then, they controlled it. It also shows that under the seeming insensibility the senses are acutely vigilant. The quart of cold water was at once perceived by the one as a herald of something disagreeable, and the bucket of water or the touch of the surgeon's hand were signs of pain to follow. In each case the will was active enough to act promptly and take the necessary steps to avoid the threatened blow. But when the danger is past and there is no objective reminder of its presence, the sway of the intellect is not maintained, it becomes dormant, and the emotional balance again becomes disturbed. So that the dictum of Paget is not sound. "It is not that I will not will, but that I cannot will," is proven to be untrue and should run more like this, "It is not that I will not will, nor that I cannot will, but rather that I am not unable, but unwilling to will."

I think that will fit most cases of hysteria. It is as though the tension of the intellect was feeble until its tension was raised by some suitable stimulus. If this intellectual temporary sleepiness happens to be at any time co-incident with high emotional excitement the combination of the two states is that known as hysteria. There is no "paralysis." The will is there, but the will is not to will. This leaves ample room for other combinations which give rise to the great variety we see in its manifestations. Those two cases which happened not far from each other during the early months of the Gazette's life have been of much help to me in understanding this protean malady.

Birds at Examinations.

I wonder if the College of Surgeons has had at any time since the birth of the Gazette the wonderful collection of birds it had at that

time. I remember seeing Partridge and Cock as a pair examining a bird student, while at another table Peacock of St. Thomas's, was giving another bird from Guy's his *viva*.

Peacock was one of those who took part in a discussion on Cirrhosis. He held that at the very onset it began with enlargement, swelling, or thickened parenchyma. Call it what you will, but the very first change was one of inflammatory thickening. We, at Guy's, were taught that it was a contractile process from the beginning. Imagine my dismay when about half way through my *viva voce* by Peacock he turned, as the subject of his questions, to the pathology of Cirrhosis, for at his side sat Wilks whom we all held as a very Apostle of pathological light, and he taught us that it was not, at the beginning accompanied by any swelling, but that it commenced from the first as a shrinkage.

One of his first questions was to ask me to describe the very beginning of the change. Of course I spoke as I had been taught, but I felt in a quandary, for I knew that the two men in front of me held opposite opinions, and that the one who was my examiner held different views to what I had just given. He also jumped as he seized on my words, and said, "Oh! So you say there is no thickening?" evidently preparing to give me a good roasting on the subject. But Wilks gave him a kick under the table and he suddenly changed the subject.

As far as I remember we were supplied with refreshment at both Colleges during the final exams., but I have quite a distinct memory that at the College of Physicians we had a very nice tea nicely served. I thought this an excellent idea for not only does it revive the physical powers, but does much to take away that very disagreeable feeling of "nervousness" or high tension from which some men suffer so acutely.

Dinners and Hospitality.

I wonder if the Dressers and House Surgeons now look forward with pleasure to the dinner to which the Staff used to invite those who had held the Senior appointments under them as eagerly as we did in our time, I suppose they do. For my own part I used to appreciate the pleasure and honour of those after dinner talks when we would close round our teachers and listen to their genial good fellowship and mellow thoughts. I would not like to run the risk of the reputation of even one being made smaller by comparison with another, but although the conversation never flagged, or even trickled, at any one which I attended, I cannot look back, even now, without feeling how privileged I have been to have had the good fortune to share the hospitality of these great men. I have a very clear recollection of many of these dinners, and the personality of the speakers, but for the reasons given will not attach names.

How cleverly some can lead a flow of talk, and while, as it were, holding the reins and guiding it along the most pleasant ways, avoiding those routes where his more experienced eye knows pitfalls of bitter feelings, such as politics, the mud of society scandal, and the dry dust of science. He does not usurp the happy chance of turning conversation into a lecture, by doing all the talk himself, but is content to repress any coltish freshness on the part of some of the more lively by the magic of his wit or embellish the drier parts by such clever touches of word painting that we seemed to be actually looking at the very thing he was describing rather than listening to a verbal description.

Ah, my old friends and fellowdiners, you, whose grey locks and shiny scalps have all now passed over, you have rejoined your old hosts at an everlasting feast where it is possible I hope once more to recall these happy times. I alone am left. I cannot recall one name or face still living who shared with me the hospitality of table and open generosity of intellect of those lovable, great men.

Conversation was never allowed to drift into argument, but I remember how, on one occasion, we were speaking each one from personal experience of the vineyards of the Continent. One quoted from a friend who was travelling through the wine districts of France with the senior partner of the great shipping firm which was then called after his name.

This man, extremely wealthy, belonged to a little coterie whose refined pleasure was not a gluttonous consumption of a large quantity, but the collection of samples of the most exclusive and delicate growths, and the giving of little wine parties where the results of search and enquiry were introduced to and discussed by the group of friends. It was with this object in view that they were then personally

investigating the different districts. They came to Chateau Lafite where, on credentials being produced, they were allowed to be initiated into the workings of the vineyard and to sample its growth.

The manager found he was in conversation with one of knowledge and discrimination, and took care to produce a worthy sample. The old shipping master was charmed. He had never tasted such claret. Here was a prize to present to his friends. He was indeed fortunate, but bitter was his disappointment when he was told it was impossible for him to have a single bottle. The question of price did not enter into the matter at all. The proprietors of the vineyard were bound by agreement to reserve the whole of their produce for the use of one man. He had the legal privilege of claiming every bottle, adding, "even the bottle we have just drunk was technically stolen." The name mentioned was an English nobleman. The manager went on to explain that although the Chateau was one of the four "First Growths" of claret, and was recognised as being able to produce a more delicate wine than any of the other three, yet their wine of a "bad" year was much inferior to the wines of the second, third, or even fourth growths in a "good" year. The vineyard name of the wines found in the open market is of no value in itself. It must be taken in connection with the date. What was the year in which it is grown? As a matter of fact, no good sample of a "good" year is ever allowed to come into the market unless by accident, etc.

As this information came direct from the vineyard itself it was worth remembering, but as the holiday jaunt was almost exactly sixty years ago, different conditions may obtain, as the nobleman in question has long since been dead, and his successor has also followed him.

Then followed another who said much the same thing of the "Johannesberg" hock, which bore the palm in the hock world, being *facile princeps*. But the General Public never had the opportunity of tasting its superlative merits whatever price they paid, as the wine which gained this high honour was made only from the grapes which grew on the south side of the mountain. The wine from the other sides was good, but not equal at all to the other. The whole of this hock from the south side at that time went to the German Court.

Then the H.S. present said that when he was some years younger he was sent on the Continent for his health, as tubercle was feared. The place selected was near where the celebrated "Tokay" wine was grown, the whole of which was monopolised by the Austrian Court and no one else ever got a bottle. On which our host, who was known to be a bon viveur and a lover of good things, spoke up and said, "Well, I have got some in my cellar which I think is genuine." "It cannot be," said H.S. "Well, I think it is," said our host, "for I gave three guineas a bottle for it and each only holds six glasses"; his face here brightened up as he added, "Shall I bring up a bottle and let you taste it and see?" "On no account," replied H.S. "It would be useless as I have never tasted it, but the custom is rigidly enforced."

(To be continued.)

Notices.

The National Union of Students of the Universities and University Colleges of England and Wales.

FOREIGN TRAVEL.

Individual students may take advantage of all the National Union Tours and Travel Arrangements. It is not necessary to form parties. In most cases students can travel independently.

Special Tours in Germany and Hungary, arranged in conjunction with the Student Organisations of these countries.

Germany (N.U.S. Special Tour No. 15.)—

A Fortnight's Tour through the Rhineland and Central Germany, visiting Brussels, Cologne, Bonn, Heidelberg, Nuremberg, Eisenach, Göttingen, Brunswick, Hamburg, etc.

Cost, including Passport, Visa, Fares, Accommodation and Food, is estimated, on basis of present prices and exchange rates, at £15.

This Tour is based on an outline suggested by the German Students' Union. German students will be provided to act as guides and couriers to the party throughout the whole tour, and they will make all arrangements for travel and accommodation at the places visited. The Tour will provide an excellent opportunity for students to gain a clear impression of Central Germany and the Rhineland.

Itinerary—

1st Day.—Leave London (Victoria, S.E. & C.R.) 8.55 a.m. via Dover and Ostend to Brussels.

2nd Day.—Leave Brussels for Cologne. Spend morning in Cologne, and see the Cathedral. Proceed at mid-day to Bonn. In the afternoon visit Königswinter and the Drachenfels.

3rd Day.—Travel up the Rhine to Coblenz. In late afternoon proceed to Mainz. (Part of this trip up the Rhine will be by boat.)

4th Day.—Morning in Mainz (Mayence). In afternoon travel via Darmstadt to Heidelberg.

5th Day.—Spend day in Heidelberg and in trip up valley of the Neckar.

6th Day.—Travel to Wurzburg, a beautiful Frankish residential town.

7th Day.—Proceed to Rothenburg, a fine specimen of mediæval town.

8th Day.—Spend day in Nuremberg.

9th Day.—Visit Eisenach.

10th day.—Visit Göttingen, historic University town, founded by King George II. of England. H.Q. of German Students' Union.

11th Day.—Proceed via Hildesheim and Brunswick to Hamburg.

12th and 13th Days.—Hamburg. Leave for return journey.

14th Day.—Return to London.

Members wishing to go on this Tour should apply *without delay* to the Hon. Sec.

Hungary (N.U.S. Special Tour No. 16)—

A Three Weeks' Holiday in Hungary, including a visit to Vienna.

Cost, including Passport, Visas, Fare, Accommodation and Food, is estimated on basis of present prices and exchange rates, at £17 10s.

This Tour has been arranged between the Hungarian Christian Students' Union and the British League of Nations Union and N.U.S. Facilities have been granted in connection with it by the Hungarian, Austrian and German Governments.

The object of the Tour is to give British Students an opportunity of seeing Hungary, and at the same time to make it possible for Hungarian Students (otherwise imprisoned by their low exchange) to visit England. British Students will pay the ordinary fares to Budapest, and the sum of £4 10s. for their three weeks' board and lodging there; but this latter sum, and their fares from Cologne to Hungary will be paid into a Fund to assist a party of Hungarian Students to visit England, where hospitality will be found for them by the League of Nations' Union. Between Cologne and Hungary they will be travelling in a special carriage, conveyed free by the German, Austrian and Hungarian Governments, and will in reality stay in Hungary as free guests in hostels and families.

Itinerary—

August 30th.—Leave London for Cologne via Ostend and Brussels.

August 31st.—Leave Cologne under direction of Hungarian Students, in special through carriage for Budapest.

September 23rd or 25th.—Leave Budapest on return journey, spending two days in Vienna en route. (If possible to arrange.)

British students are asked to state on back of Application Form whether they prefer to stay:—

(a) In private families, or together in a hostel (for men only);

(b) In Budapest, or a country town, or the country.

Attractions—

BUDAPEST.—Sight-seeing, boating, tennis, etc.

COUNTRY TOWN.—Tennis, amusements, etc.

COUNTRY.—Hunting, tennis, boating.

If Students so desire, expeditions will be arranged to places of historic interest, mountains, and lakes, either free of charge or at a very low rate (3s. or 4s.).

Special arrangements can be made for Medical Students to visit Foreign Hospitals, Engineering Students to visit Foreign Works and Power Stations while on any of the Tours, etc., etc.

Application Forms should be sent direct to the Headquarters Office. During the Vacation it is not necessary to have these signed by the local representative of the National Union. The Certificate (item 7) may be deleted.

See National Union Posters and Pamphlets.

F. W. McCOMBIE,
Hon. Secretary.

Office: University of London Union Society Building.
Malet Street, W.C.1.

West End Hospital for Nervous Diseases.

Out-Patient Department, 73, Welbeck St., W.1.

Applications are invited for Hon. Clinical Assistants as under:—

Wednesday afternoons, 1.30—4.30 p.m. (2 vacancies).
Friday afternoons, 1.30—4.30 p.m. (2 vacancies).

Applications with copies of two recent testimonials should be received by the undersigned not later than August 21st.

J. P. WETENHALL, *Secretary.*

There is a vacancy for a qualified English Dentist in one of the premier Hill Stations of India, with good prospects of advancement for a good Dentist. Full particulars may be obtained from the Medical School Office between the hours of 9.30 and 1 p.m.

Reviews.

Hints to Probationer Nurses in Mental Hospitals. By R. Eager, O.B.E., M.D. (Messrs. H. K. Lewis & Co.). Price 1s. 6d. net.

This useful little volume contains much information that is likely to prove extremely valuable to probationers in mental wards. An excellent summary is given of rules of general conduct in dealing with mental patients. Much of what this section contains may be epitomised in the one word—tact. The next section deals quite adequately with the course of action to be adopted in various emergencies, such as choking, fits, suicide, fire, etc. A section on ward duties follows, and the book is concluded with an admirable, if very elementary, exposition of modern psychology.

This little book is well worth its price.

Surgical Pathology. By Eric Pearce Gould, M.D., M.Ch., F.R.C.S. (Messrs. J. & A. Churchill.) Price 6s. net.

The Students' Synopsis Series has given the student many useful books, but this little manual is not the type of book to appeal to a student who wishes to put his pathological knowledge upon a sound basis.

The subject-matter is indeed excellent, but the whole book is so extraordinarily condensed that it makes unusually dry reading even for a book which is admittedly a "cram" book.

A student who has learnt his pathology well, and is gifted with persistence, might do himself a great deal of good by reading through this volume just before an examination. For this purpose, and for this purpose alone, the book may be recommended as a useful summary of Surgical Pathology.

The Ophthalmology of General Practice. By Malcolm Hepburn. (Messrs. Cassell & Co., Ltd.)

Mr. Hepburn has endeavoured to bring together in a readable form the main facts of ophthalmology essential to the General Practitioner, and we may say that he has succeeded.

As would be the case the book is elementary, and clinical facts rather than pathological are emphasised, and the General Practitioner is instructed in interpreting those symptoms which he is likely to notice, and to notice others easy of verification.

All the main headings, such as Iritis, Glaucoma, Cataract, usually found in ophthalmic text books are passed in review, and the main clinical points noted. The book is especially valuable because it is so well illustrated; not only are the illustrations numerous, but they are good and very well coloured and reproduced. The book is worth buying if only for its illustrations.

It is assumed that the practitioner has an acquaintance with the ophthalmoscope, and is willing to spend the time and trouble necessary to work out a refraction by retinoscopy. To those willing to do this the chapter on Fundus conditions and Errors of Refraction are especially valuable.

There are various, rather doubtful facts recorded, as on page 40, where atropine irritation is suggested as being due to prolonged use of the drug, which is far from being the case.

Leeches as a means of relieving intense ocular pain from iritis, cyclitis and inflammatory glaucoma, is, as far as we could find, not mentioned, but the operations usual in these conditions are; we should have preferred an exhaustive account of all remedies, harmless in their application, and strikingly beneficial in their effects, to be inserted, rather than an account of operative methods, which the General Practitioner would be very ill-advised to try unless absolutely cut off from all expert help.

A chapter on remedies, household and others, in ocular trouble might be inserted in the next edition.

When to bandage the eye, and when not?

What to do in conditions of pain?

How to improve visual conditions by adjustments of light, etc., in those for whom operative interference is not possible.

The importance of general hygienic conditions, especially the teeth and why?

A few hints as to arranging the life of the blind—children, adults, and old people, so as to soften the necessary hardship of such conditions;—would be most helpful to the General Practitioner and most useful in lessening the too specialist position of ophthalmology which is so noticeable to-day.

The General Practitioner has after all to live with and among his patients, and it is the practical facts which he will be asked about, without any doubt, at some time or other.

Change of Address.

Surg.-Colonel W. Culver-James, Cadmore End, High Wycombe, Bucks.

Miss E. M. S. Johnston (late Sister Addison), Matron, Royal City of Dublin Hospital, Upper Baggot Street, Dublin.

A. B. Danby, F.R.C.S., 3, Calthorpe Road, Five Ways, Birmingham.

Lancelot Horsley, 11, The Hawthorns, Church End, Finchley, N. 3. Telephone: Finchley 2860.

C. A. Lucas, R.N., Saanich Health Centre, Royal Oak, Victoria, B.C.

Publications Received.

British Medical Journal, St. Bartholomew's Hospital Journal, St. Thomas' Hospital Gazette, London Hospital Gazette, Middlesex Hospital Journal, St. Mary's Hospital Gazette, Charing Cross Hospital Gazette, St. George's Hospital Gazette, Magazine of the London (Royal Free Hospital) School of Medicine for Women, Nursing Times, Abstracts of Bacteriology, New York State Journal of Medicine, Medical Journal of South Africa, Hospital and Health Review, The Prescriber, The Antiseptic (India), King's College Hospital Gazette, Burma Medical Times, University College Hospital Magazine, Indian Medical Record.

SUB-ED.—C. H. C. T.

GUY'S HOSPITAL GAZETTE.

VOL. XXXVI., No. 891.] SEPTEMBER 2, 1922. [NINEPENCE.

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Passim.

OUR heartiest congratulations to Mr. A. H. Douthwaite who was recently awarded the Charles Murchison Scholarship in Clinical Medicine. This Scholarship was founded in 1880 to perpetuate the memory of Dr. Charles Murchison, and the award is made every year alternately by the University of Edinburgh and by the Royal College of Physicians of London after a competitive examination. This is open to any student of medicine, whether holding a medical qualification or not, who, subsequently to the date of passing his professional examination in Anatomy and Physiology for a medical qualification, has studied for a period of not less than two and a half, and not more than five, years at a medical school in London.

Mr. Douthwaite's achievement is all the more worthy in that he not only won the Scholarship while still an H.P., but also tied for the first place with a Medical Registrar at King's College Hospital who is, we believe, a Member of the Royal College of Physicians.

We may well be proud of the results of this Scholarship when it is remembered also that Mr. J. V. C. Braithwaite gained second place on the last occasion on which the examination was held in London.

WE offer our sincere apologies to those Guy's men who were successful in the July Examination for the Primary Fellowship for the omission of their names from the Pass List published in our last issue. We cannot pick out individuals from the list (published on page 362) which is so remarkably big for the Primary Fellowship, but we congratulate each and all most heartily, the more so as they enabled Guy's to tie with one of the other hospitals for the honour of possessing the largest number of successes for this examination.

WE wish to draw the attention of all to a notice on page 362 concerning the City and Hospitals' Charity Athletic Contest which is being held at Honor Oak Park, on Saturday, September 9th, at 3 p.m. In this contest a team representing the United Hospitals Athletic Club, will compete against teams representing respectively the Banks, Insurances, and the Stock Exchange. The *Financial Times* have very kindly presented a Challenge Cup to go to the winning team and have also provided the sum of a hundred guineas to cover the cost of any expenses which may be incurred.

The meeting should prove a great success from every point of view, and we extend our best wishes to the United Hospitals' Team,

which, from past results, stands quite a good chance of winning the Challenge Cup.

To the incentive of a very enjoyable afternoon can be added the fact that the entire proceeds of the meeting will be divided amongst the Hospitals which comprise the United Hospitals' Athletic Club, and we feel sure that all Guy's men will make a special effort to turn up. The prices of admission will fit the pocket of any student, and tickets, 1s., 2s., or 3s., may be obtained from Messrs. L. G. Housden, R. S. Chambers, and J. L. Faull.

Our contemporary, the *University College Hospital Magazine*, in its latest issue, has put forward a scheme, bold, to say the least of it, which we think might well meet with greater prominence amongst the various hospitals.

We offer no apologies for reprinting the following article on the subject, for we feel that it affords an excellent and clear outline of the scheme :—

"A great deal of feeling has been aroused by the appeal of the University of London Athletic Union to the Senate for an annual subscription from every student towards University athletics, mainly with the object of providing adequate playing-fields for University fixtures in football, cricket, hockey, etc., and also for the provision of a boat-house.

Laudable as this object may appear to be, we do not feel that it is justified unless it caters for that section of student life which has interests apart from athletics, for example, the activities of the Debating Society and of the University of London Union Society, and if this is to appeal in any way to the medical side, it must offer something to the United Hospitals Athletic Club as well, such as a neutral ground for their cup ties.

Let us analyse the present position. The University of London Athletic Union wants a ground of some twenty acres with suitable pavilions, costing, it is estimated, some £30,000. If this is to be carried out they want an annual income of, say, £5,000, and, at present, their only hope of getting it is from voluntary subscriptions from certain Colleges and Schools of the University whose heads have consented to suggest to new students entering next session that they should subscribe ten shillings per annum towards the U.L.A.U. We feel that their chances of obtaining an income of £5,000 in this way are remote in the extreme, and unless £5,000 annually is assured, nothing worthy of this University can be done or should be attempted.

Let us consider the possibilities—and probabilities, provided a certain amount of "give and take" is shown by the three bodies concerned, namely the University of London Athletic Union, the University of London Union Society, and the United Hospitals Athletic Club. It is our firm opinion that any and every student of this great University who is taking a course at a school of the University, irrespective of whether he be a matriculated student or not, should be willing—yea anxious—to pay his scot to university life. In this University there are more than 20,000 students who would qualify for this privilege. Let the contribution of each equal ten shillings, and an annual income of £10,000 would be assured.

Let 25 per cent. of this go to each of the three bodies concerned, which would mean £5,000 a year for University and United Hospital Athletics, £2,500 a year for the University of London Union Society, which would help University athletics by providing committee rooms, central offices where notices of all university functions and fixtures could be posted, and last, but not least, a general common room, or even club, where men, both present and past, of all colleges and medical schools, could meet their fellows and be certain of at once becoming acquainted with current university activities. Such offices already exist in embryo, namely, the Pickwick Hut on the Bloomsbury site.

There would still remain £2,500 which could go towards the provision of a sinking fund.

We strongly feel the necessity for a general meeting of students of the University to discuss such a scheme as outlined above, and we are convinced that if a resolution in favour of the scheme were passed at such a meeting it would receive the whole-hearted and material support of all the institutions of the University, and of the Senate, because the three bodies concerned,

namely, the University of London Athletic Union, the University of London Union Society, and the United Hospitals Athletic Club, together represent all that counts in the student life of the University.

These three bodies must consider not only their own interests, but those of each of the others; for instance, by co-ordination of fixtures between the University of London Athletic Union and the United Hospitals Athletic Club it would be possible to put teams into the field which would be second to none amongst the universities of the country, while the Union Society would materially help university life by providing platforms for the discussion of university problems."

There are, however, a few points which have been overlooked by the writer of the above article. From the point of view of the Hospitals it must be realised that there is at present no *United Hospitals Athletic Union* which administers *all branches* of sport in the various hospitals. True, there is the United Hospitals Athletic Club; but this body is connected only with athletic sports, and is entirely separate from the U.H. Rugby, Cricket, Swimming, and other athletic clubs.

It will be seen, then, that before this scheme can be brought into form, a new body, having some administration, especially financial, over all branches of hospital sport, would have to be set up. This seems to be a fundamental condition for the success of the scheme, but whether such a body could be brought into being would, we think, rest with the captains and secretaries of the already existing United Hospital Clubs.

Another important factor in the question is that a body such as the University Union Society, before giving its consent to the scheme, must have satisfactory guarantees that it will be ensured an absolutely adequate minimum revenue per annum. Whether the Union could, in the event of its securing a large new building on the new University site, maintain itself on an income of £2,500, is not for us to say. It is, however, quite clear from all points of view that the number of students paying the levy of 10s. must be in the region of 20,000 and not much less, in order to ensure the three main bodies concerned an adequate individual revenue. In this connection it must be remembered that, although the University of London is the largest in the kingdom, its numbers will not always be so great as they are now. The success of the scheme depends again on its adoption by the students of all the Colleges and Hospitals and not only of one or two.

No mention is made of any of the smaller University Societies, which each need an income, though an extremely small one compared with the three larger Societies. We conclude that these small bodies would be able to draw on the sinking fund to a minor extent, though, of course, they would be able to make use of the Union premises.

The levy itself is small, and should meet with no objection, though we feel that its acceptance must be by the students themselves. Any form, however small, of compulsion from above would be sure to create friction.

The scheme, as we have said, is certainly a bold one, but we wish it all success, for we feel that it will mean the solution of many of the difficulties which are at present insuperable. We hope to hear more of it from others of our contemporaries and from officers of the various United Hospitals Clubs.

C. H. C. T.

Change of Address.

R. J. Hodgkinson, Maquncor, Grayshott, Hindhead, Surrey.

Frederick W. Day, L.D.S., "East View," The Broadway, Thorpe Bay, Essex. (Telephone: 58 Thorpe Bay.)

Three Unusual Cases.

Hæmangioma of the Rectum.

H. B., aged 48 years, stated that he had slight hæmorrhage from the rectum. He admitted having had previously, since the age of 12, eight serious attacks of passage of copious blood per anum.

He carried about in his pocket a letter from his doctor advising that in any case of recurrent rectal hæmorrhage he should immediately go to bed. There was no question of a hæmophilic condition. The letter also stated that he had been examined per rectum during an interval between attacks when diagnosis of hæmangioma was made.

I admitted him to hospital for observation; he was confined to bed and kept on light diet. The constant trickling hæmorrhage continued from the rectum despite irrigation of the bowel with iced liquor, hamamelidis, and the administration of morphia night and morning.

On the third afternoon, while the patient was sitting up in bed having tea, he suddenly became white and collapsed. He was found to be lying in a large pool of blood. The pillows were removed and the end of the bed was raised. Pulse 120; the systolic blood pressure had fallen from 180 mm. Hg. to 80 mm. Hg. After half an hour he was conscious and comfortable. He improved quickly in the next few days and was kept under morphia.

Two eminent proctologists were now called into consultation. In an attempt to stem the trickling hæmorrhage, the rectum was coated with kaolin paste. Hæmorrhage still persisted, accordingly a blood transfusion of one pint by the citrate method was performed. But the hæmorrhage continued, pulse was imperceptible, air hunger supervened, and the patient died.

Foreign Body in the Bronchus.

N. R., aged 42 years, applied to me for treatment because of irritable cough and foul sputum, worse in the morning.

Previous history was good. After questioning he stated that the bronchitis had been getting worse since twelve months. He later added with unconcern that eighteen months previously he had gone to sleep with a small gold denture in his mouth and perhaps swallowed it.

On percussion there was some dulness at the region of the right lung root. This was the only physical sign. On radioscopy the small metal denture was demonstrated clearly in the right bronchus.

The patient was referred from the Hertford British Hospital to Professor Le Maitre at the Saint Louis Hospital.

After chloroform anæsthesia a laryngeal tube was passed by mouth, and through this a catheter was inserted with rubber tubing attachment to a vacuum pump. About one and a half pints of pus were evacuated from the right bronchus region. It was now possible to view part of the object in the right bronchus. To obtain better access, an extensive tracheotomy was performed and the tube inserted through the tracheal wound. Many attempts were made to dislodge the denture, but it was impacted so firmly, that after two and a half hours of tugging with the laryngeal forceps the attempt was abandoned.

Next day the patient had a temperature, and a week later unfortunately died from extensive broncho-pneumonia.

Cerebral Hæmorrhage.

R. G., aged 26 years, was admitted to hospital suffering from concussion and shock following a motor-cycle accident. There were no signs of compression. The patient desired to proceed home, but was advised to remain in hospital for observation. During the night the nurse reported that the patient had died in bed.

Post-mortem revealed a circular fracture around the foramen magnum with a small adjoining hæmorrhage.

This case illustrates the statement by Macewen that in basal cerebral hæmorrhage pressure on the respiratory centre may only occur when patient is moved from the sitting to the horizontal position.

GRAYDON O. HUME,
M.B., B.S.

Notices.

Metropolitan Asylums Board.

CHILDREN'S SERVICE.

Appointment of Assistant Medical Officer.

The Metropolitan Asylums Board invite applications for appointment as Assistant Medical Officer at the Downs Hospital for Children, Sutton, Surrey.

Candidates must be qualified by law to practise both medicine and surgery in England. Experience in the administration of anæsthetics, in nose, throat and ear work, and in the performance of operations for the removal of tonsils and adenoids will be recommendations.

The hospital contains 360 beds. The cases are received from the Metropolitan Boards of Guardians and the London County Council. Special provision is made for the treatment of cases of ear disease, and a consulting aurist is attached to the institution.

The Assistant Medical Officer will take charge of the hospital in the Medical Superintendent's absence.

The salary is £478 per annum, together with a bonus which at the present rate amounts to £101 14s. per annum. The present total salary is thus £579 14s. The candidate appointed will be required to live in the institution and to pay for board, lodging and washing at the rate laid down by the Finance Committee of the Board. (Present rate £130 per annum).

Preference will be given to candidates under 30 years of age.

Forms of application may be obtained from the Clerk to the Metropolitan Asylums Board, Embankment, London, E.C.4, to whom they must be returned not later than 10 a.m. on 8th September, 1922.

G. A. POWELL.
Acting Clerk to the Board.

August, 1922.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS.

October Class, 1922.

A Course of Instruction in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals on the days and at the times stated below.

N.B.—Attendances may be commenced during the the second month of the course except at the South-Western Hospital, but Certificates in respect of that course will only be granted to students who join not later than the end of the first month.

Eastern Hospital, Homerton Grove, Homerton, E.9. J. Wilkins, M.R.C.S., Medical Superintendent. Monday and Thursday, at 2 p.m., beginning 5th October.

North-Eastern Hospital, St. Ann's Road, Tottenham, N.15. F. H. Thomson, M.B., Medical Superintendent. Monday and Thursday, at 11 a.m., beginning 5th October.

North-Western Hospital, Lawn Road, Hampstead, N.W.3. E. W. Goodall, M.D., Medical Superintendent. Tuesday and Thursday, at 2 p.m., beginning 3rd October.

Western Hospital, Seagrave Road, Fulham, S.W.6. R. M. Bruce, M.R.C.S., Medical Superintendent. Tuesday and Friday, at 2 p.m., beginning 3rd October.

South-Western Hospital, Landor Road, Stockwell, S.W.9. F. Foord Caiger, M.D., F.R.C.P., D.P.H., Medical Superintendent. Tuesday and Friday, at 2 p.m., beginning 3rd October.

Grove Hospital, Tooting Grove, Tooting Graveney, S.W.17. J. H. Whitaker, M.D., Medical Superintendent. Monday and Thursday, at 2 p.m., beginning 5th October.

Park Hospital, Hither Green, Lewisham, S.E.13. T. H. Woodfield, M.D., D.P.H., Medical Superintendent. Wednesday and Friday, at 11 a.m., beginning 4th October. (Train from Charing Cross at 10.22 a.m., and London Bridge (S.E. & C.R.) at 10.29 a.m. to Hither Green).

Brook Hospital, Shooter's Hill, Woolwich, S.E.18. J. B. Byles, M.D., Medical Superintendent. Monday and Thursday, at 2.30 p.m., beginning 9th October. (Motor Omnibuses from Blackheath Station (South-Eastern and Chatham Railway) to the Hospital).

The succeeding Course will commence in January, 1923.

A two months' Course will also be held in November and December at the South-Eastern Hospital, for particulars of which see separate Notice.

Students who desire to attend a Course of Instruction must, *before* attending at the Hospital, bring between 11 a.m. and 4 p.m. on any weekday (*except Saturday*) or send by post to The Acting Clerk to the Metropolitan Asylums Board, Embankment, E.C.4.

(1) Authority from the Dean of the Medical School.

(2) Fee, £3 3s. for 2 months' Course or £4 4s. for 3 months' Course. Cheques to be made payable to "The Metropolitan Asylums Board."

The Student must definitely ascertain *before* taking out his course whether he requires a 2 or 3 months' course. In the event of his taking out a

three months' course, the extra £1 1s. will not be refunded to him, if he finds subsequently that a two months' course only is required.

(3) Full Name and Address and Name of Medical School. (N.B.—The Name must be in *Full* and must be *distinctly written*).

(4) The Names of at least two of the above Hospitals, arranged in the order in which the Student would prefer to attend, in case the classes at any of the Hospitals should be already full.

By Order,
G. A. POWELL,
Acting Clerk to the Board.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS.

A Course of Instruction (Two months) in the Diagnosis and Treatment of Fevers, will be held during November and December, 1922, at the South-Eastern Hospital, Avonley Road, Old Kent Road, S.E.14. By F. M. Turner, M.D., Medical Superintendent, on Tuesdays and Fridays at 11 a.m., beginning Friday, 3rd November.

Students who desire to attend this Course of Instruction must, *before* attending at the Hospital, bring between 11 a.m. and 4 p.m. on any weekday (*except Saturday*) or send by post to The Acting Clerk to the Metropolitan Asylums Board, Embankment, E.C.4.

(1) Authority from the Dean of the Medical School.

(2) Fee, £3 3s. for two months' Course. Cheques to be made payable to "The Metropolitan Asylums Board."

(3) Full Name and Address, and Name of Medical School. (N.B.—The Name must be in *Full* and must be *distinctly written*).

For particulars of the October—December Course at the other infectious hospitals, see separate Notice.

By Order,
G. A. POWELL,
Acting Clerk to the Board.

Charity Athletic Contest.

Next Saturday, September 9th, Honor Oak Park will be the scene of the positively last appearance of the United Hospitals Athletic Club team this season. On that day they will meet the United Banks, Lloyds and the Stock Exchange in a contest for the fifty-guinea Challenge Cup, presented by the "Financial Times." Tickets are three, two and one shillings each, and all the money taken is to be divided between the five hospitals which form the United Hospitals' Athletic Club. Tea and ices (or hot soup, according to the weather) will be obtainable on the ground; a band will be in attendance, and there will be races to watch in one's spare moments. All expenses have been defrayed by the generosity of the "Financial Times," and it is hoped that all who can will visit the sports and when there buy one of the programmes, which have also been presented. From this hospital, Steyn, Lacey, Albertijn, Gough, Hutchinson, Faull and Jago will be performing, so that the competition will hold a large Guy's interest.

To those who cannot be at Honor Oak Park, we suggest that it would be a graceful act to purchase a shilling ticket, or even a two or three shilling one, any of which may be obtained from R. S. Chambers, J. L. Faull or L. G. Housden.

Reviews.

Oto-Rhino-Laryngology for the Student and Practitioner. By Dr. Georges Laurens. Translated by H. Clayton Fox, F.R.C.S.(Ireland). Second English Edition. 589 Illustrations. Price 17s. 6d. net.

The subject of Oto-rhino-laryngology is so wide that the task of covering the ground in a small book is no easy one, and is apt to lead to a condensation of facts in an unpalatable form.

In his Oto-rhino-laryngology Dr. Georges Laurens has overcome all difficulties and has produced a most attractive and readable work full of practical hints valuable alike to students and practitioners who are called on to treat ear and throat cases. At the same time the book is read with pleasure and advantage by those who already possess knowledge of the subject.

The key-note of the book is practical application, and this note is faithfully sustained throughout, aided by clear diagrams and illustrations. The Author makes a special point of explaining "what to do" and "what not to do" in dealing with treatment of most of the conditions discussed; this is a most valuable feature and the advice given will prove most sound.

In this the second English edition some interesting additions have been made; a chapter on respiratory exercises clearly illustrated, a line of treatment most frequently advised, but seldom described.

There are chapters too on Industrial accidents and their relation to Oto-rhino-laryngology, also on Life Insurance in relation to the specialty, both containing useful information.

The translator has been highly successful and is to be congratulated on bringing the work before English students and practitioners who could not wish for a better or pleasanter book on the Ear, Nose and Throat.

Pass List.

Royal College of Surgeons.

F.R.C.S.—Primary Examination. May, 1922.

W. D. Doherty.
C. Gill-Carey.
A. C. Hampson.
J. J. Lewinstein.
D. W. C. Northfield.
B. G. Scholefield.
W. G. Sears.
H. G. Wimbush.

Exophthalmic Goitre.

CLINICAL LECTURE BY MR. SLESINGER.

GENTLEMEN, — Exophthalmic or thyrotoxic goitre is a disease of such varied symptomotology and of such grave importance to its victims, that any remarks upon the surgery of this condition must largely embrace other aspects of the question. I think it of great importance for you to investigate for yourselves as carefully as you can the claims which are made for both medical and surgical treatment of this disease, because ultimately it will depend largely upon your judgment and advice whether such cases come to operation or not, and more important still, you will have to decide the period of the disease at which operation is undertaken.

Before discussing treatment, however, I want to present to you a picture of the chief symptoms of exophthalmic goitre, because it is on a correct estimation of the symptoms that treatment depends, and also because it is a condition which will repay your close observation in that it gives you an insight into the physiology of various organs of the body such as can be obtained from the study of few other diseases.

If I tried to express it briefly, I would say that exophthalmic goitre represents a generalised and continued stimulation of the whole sympathetic and parasympathetic system, such stimulation being the result of overactivity of the thyroid and being associated with disturbances of other glands of the body.

To make my meaning clearer I would say that the temporary changes in the individual in response to an intensely unpleasant stimulus, as in acute fright or the reactions of combat, gives you a snapshot of the state of which exophthalmic goitre is an engraving.

Eyes starting and glaring, increase of pulse and respiration, sweating and dilatation of skin vessels, tremor and increased muscular tone, emptying of bladder, rectum and stomach, mobilisation of the body's food reserves with increased metabolism, rapid and increased response to all external stimuli—such is the picture of the organism under sympathetic control, and such too, but with the details filled in, and with certain additions, since the stimulus in this case is chemical, is the picture of an acute case of exophthalmic goitre.

In giving you the symptoms of this condition in greater detail it will be best to elaborate the systems in turn, since nearly all are variously affected, though my description to-day can be only a brief one.

Goitre.—The enlargement in Graves' disease is variable, but never so large as in certain severe non-toxic goitres. The gland in the early stages feels granular and firm, and is often tender on deep pressure, unlike most other goitres. Later in the disease it becomes firmer and harder as fibrous changes occur. The vascularity is greatly increased, pulsation can be seen, bruits can be heard over the thyroid vessels, and frequently a thrill can be felt. At times the enlargement is more marked on one side at first, and if so there is sometimes unilateral exophthalmos for a time, usually on the same side. The goitre does not correspond in size to the severity of the complaint, though microscopically the degree of hyperplasia in the gland does bear a close relationship to the clinical picture.

Ocular Signs.—The most obvious of these is exophthalmos, which is present in varying degree in practically all cases, and is accompanied by a curious glaring appearance of the eyes. The cause of this exophthalmos has been variously explained, but is still far from clear. It is usually said to depend on an increased deposit of fat in the orbit, but careful post-mortem investigations fail to substantiate that, nor does it fit the rapid changes which exophthalmos sometimes undergoes. Late in the disease, however, an undoubted adaptive change occurs in the anatomy of the orbit, which accounts for the persistence of the exophthalmos after all other symptoms have cleared up in certain cases. Of the many explanations advanced, the one that appeals to me as most likely is that the exophthalmos depends upon chronic over-stimulation of Landström's muscle, which you will remember is a sheet of muscle fibres running roughly from the tarsal plates to the equator of the eye. There are several other ocular symptoms to which unfortunately the observer's name has been attached, which makes them difficult to remember and somewhat apt to be confused. The chief of these are the following :—

Dallrymple's Sign is the marked enlargement of the palpebral fissure, which is mainly responsible for the glaring appearance of the eyes.

von Graefe's Sign depends upon the following facts. In the normal eye, when made to follow an object moving downwards in front of it, the upper eyelid follows the globe in its downward movement, a close coordination existing between the two. In Graves' disease, while the eyelid begins the movement, it lags behind the globe, and stops while the latter continues to rotate, finishing its downward movement appreciably later.

Kocher's Sign.—If the finger is held horizontally in front of the eye and is made to move suddenly upwards, in the normal person both eyeball and upper eyelid rise together. In exophthalmic goitre, however, the upper lid frequently starts first with a jerk, and is only later caught up by the rotating eyeball. In my experience this is a very early sign, and often positive when the von Graefe sign is absent.

Moebius Sign.—In a normal person if the gaze is fixed on an object brought nearer and nearer to the eye, a considerable degree of convergence can be obtained and kept up for some time. In Graves' disease, however, if this is attempted, one or other eye will, in a short time, swing out straight to the front, convergence being kept up by one eye only. This sign is, of course, only of value if the refraction of both eyes is normal.

Stellwag's Sign.—In normal people, winking of the eyelids occurs from three to ten times a minute. In Graves' disease these winks are much diminished, often to less than one per minute. Pigmentation of the eyelids is also very common, and I shall mention it later.

Cardio-vascular System.—Tachycardia is one of the most prominent signs in this disease. The rate of course varies according to the severity of the attack, but remains persistently high throughout. A striking feature is the fact that the rate remains high with the patient in bed, and even during sleep. It becomes greatly increased on the least exertion, but seldom varies much in the downward direction. Thomson put it well in saying "The Graves' pulse runs as fast or faster than in fever, by day and by night and always in sleep with less change at each counting over long periods than in any other complaint."

Palpitation is often a most troublesome symptom. It comes on in attacks, frequently at night and makes sleep impossible, but does not bear any direct relation to the tachycardia. Sometimes it is accompanied by acute pain in the cardiac region, coming on in attacks much like true angina pectoris.

Thyrotoxic Heart.—This condition is quite distinct from the mechanical type of goitre heart I have often shown you in cases of simple goitre. It is frequently of the gravest significance, and the most frequent cause of death. In the early stages of Graves' disease the heart is usually quite normal, but later there are usually well-marked changes. The heart beats are transmitted violently to the chest wall, and the whole thorax is sometimes shaken. A thrill can frequently be felt, and the apex beat is sudden and bounding. There is often great dilatation, chiefly of the left heart, and frequent functional bruits. Hypertrophy occurs seldom, which seems to suggest a direct action of the thyrotoxic poison on the heart muscle.

The *blood changes* are usually well marked, and of importance from the surgeon's point of view. Red cells are little altered in numbers or in character. There is a leucopænia varying from 3,000 to 6,000 white cells, and a marked relative lymphocytosis, the lymphocytes being from 50 per cent to 60 per cent of the total white cells, the polymorphonuclears being correspondingly decreased. At the same time the coagulation time of the blood is a good deal longer than normal, which together with the unusual thinness and friability of the thyroid vessels accounts for the troublesome bleeding sometimes seen at operation.

Muscular System.—Tremor is one of the important muscular signs of Graves' disease. It may be localised or general and is sometimes limited to the upper extremities, being then more marked in the hands and extended fingers. Tremor may be observed in the tongue and in the lips even when closed. When half shut the eyelids may show tremor which becomes more marked when they are tightly closed. This is known as the Rosenbach sign. The chief characteristic of the tremor is its fineness, the oscillations being of small amplitude—varying in rate from 7 to 10 per second.

Great muscular fatigue is characteristic of exophthalmic goitre patients. They suffer from spells of marked asthenia, particularly later in the course of the disease, and they are even more tired in the morning than they are at night. This is probably an adrenal symptom,

and corresponds to the diminished size of the adrenals as found post-mortem. Another instance of this fatigue is the sudden giving way of the knees of which these patients complain, an accident particularly apt to occur while going downstairs.

Gastro-intestinal System.—Gastro-intestinal symptoms are some of the gravest from which these patients suffer, and a true interpretation of them is essential for prognosis and treatment. They often occur very early in the disease, and diarrhœa especially is so frequent in the early history of these cases as to be something in the nature of a warning symptom. The digestive disturbances are distinctly specific, they appear, continue and disappear without apparent cause and occur in cycles during the course of the disease. They show none of the signs of inflammatory conditions, they usually correspond with a marked increase in all the other thyrotoxic symptoms and they resist all forms of medical treatment. In such a gastro-intestinal crisis the usual symptoms are loss of appetite, nausea, flatulence, vomiting and diarrhœa. Vomiting, when it occurs, happens several times a day, with no relation to food, and X-ray examination at such periods shows the stomach in a state of more or less constant spasticity. Nothing is as yet certain about the conditions of gastric secretion at this time, and that is a matter that requires investigation.

Respiratory System.—The respiratory rythm in Graves' disease is abnormal. It is rapid, superficial and irregular, and alternates with periods of apnœa themselves interrupted with occasional sighing respirations. Another characteristic is that inspiration and expiration are exactly equal in length, and that the amplitude is shorter than in normal people.

Shortness of Breath is the symptom complained of by the patients, and although in late cases this may be partly cardiac, it usually represents undoubtedly a direct action on the respiratory centre.

Genital System.—The main effect of the disease on the genital system is one of hypofunction. Menstruation, though occasionally excessive, usually becomes irregular and scant and often stops altogether for months or years. Premature menopause frequently occurs. The sexual appetite is markedly diminished, and in men there may be atrophy of the testicles. When the thyrotoxic symptoms subside, menstruation usually begins again, and in my opinion the most favourable single prognostic sign in Graves' disease is the recurrence of menstruation.

Cutaneous System.—Vasomotor changes are frequent, and the patient always complains of a feeling of heat. The hands and feet are warm, the patient requires to wear very little clothing, and complains of frequent and uncomfortable flushes. Hyperhydrosis is common. They sweat continuously and profusely, by day and by night, the sweat being usually free from odour. This sweating is, to a certain extent, cyclic, and is most marked during the crises. Transient urticaria is common.

The *Hair* becomes dry and brittle and falls out, a condition not limited to the head only. This falling of the hair diminishes with the other toxic symptoms. Vitiligo is sufficiently common in these patients to be more than a co-incidence, and in common with the frequent pigmentation seen in the eyelids and elsewhere is probably of suprarenal origin.

Nervous and Mental Systems.—These patients are emotional, irritable, restless, and unstable. Unlike the neurasthenic they cannot tell you their symptoms at length, because they are always anxious to get up and away. They are full of plans for future achievements, but lack any concentration to carry them out. They laugh and cry without any cause. They become excessively irritable. They frequently take great dislikes to those whom formerly they have loved, and a quite unusual proportion are, if married, separated from their husbands. Occasionally there is acute delirium, and a small proportion of these cases end in asylums.

Metabolism.—The metabolism in Graves' disease is increased greatly above the normal, and that increase affects both proteins, fats and carbohydrates. Observations of the basal metabolic rate as calculated from the respiratory exchange have been made in great numbers in recent years, and show that in this disease the basal metabolic rate is always greatly increased, the degree depending on the severity of the disease. The appetite is usually large, but in spite of this, loss of weight occurs, often to a marked extent, being particularly severe during the crises in the disease. The sugar tolerance in Graves' disease is lowered and glycosuria is not uncommon.

The Course of the Disease.—Although various symptoms may at times become acute, the whole course of the disease is essentially chronic. The logical outcome of exophthalmic goitre is myxœdema, the thyroid burns furiously for a period, and in the end it either kills the patient or burns itself out, either completely with the development of myxœdema or partially with a varying degree of restitutio ad integram. The cases vary considerably in duration, and fulminating cases occur, but on the average the duration of the disease is roughly about three years. In the average case the signs and symptoms progress more or less for the greater part of the first year, and then there is usually a crisis, marked by an increase in all symptoms, and frequently associated with gastro-intestinal symptoms and marked loss of weight. This continues for a varying time and is followed by a marked and sudden amelioration of all symptoms. Such an improvement will continue for a period perhaps of months, followed by another relapse, with increase of all symptoms and leading up to another crisis, which, however, is usually less severe than the first. If death occurs, it is usually during or at any rate near to one of the crises in the disease, whereas in a favourable case, sooner or later all the symptoms gradually become less severe and the patient recovers, usually, however, with some degree of permanent damage.

Treatment.—The treatment of this disease resolves itself into one of three things: medical treatment, X-rays, and surgery.

I do not propose to enter into details of medical treatment, except to say that Marine has pointed out that no fewer than 239 drugs and other methods have been credited with the cure of this condition in the literature. You must draw your own conclusions from that fact, but it does not tend to give one any great confidence in any particular one of the 239 methods. The prognosis for hospital cases under medical treatment has been very excellently put by Dr. J. M. H. Campbell, whose admirable paper in the *Quarterly Journal of Medicine* you should all read. I can summarise his figures by saying he found a mortality directly attributable to the disease of 15 per cent., a figure agreeing closely with other observers. Mortality is not, however, everything, and I want you to realise that this disease is a chronic one, with an average duration of three years, and if you do that you must visualise also the fact that even when recovery more or less complete ensues, the patient has had to suffer a lengthy period of chronic invalidism, with all that that entails both for herself and her family.

In regard to X-rays, I will be even more brief. X-rays undoubtedly improve the *early* cases, but—and I think it is a very big but—relapses are extremely common; myxœdema is not unknown, and lastly, and I think, perhaps, most important, the surgery of exophthalmic goitre is very considerably increased in risk, from adhesions of the gland to neighbouring structures after X-ray treatment.

Finally, I come to surgery. There can, I think, be little doubt in anyone's mind that the best treatment in theory, with our present limitations in therapeutics, is surgery, given always that the risks are not big. Dr. Campbell finds that the surgical mortality at Guy's is very closely similar to the medical mortality. On the other hand, the large American clinics have shown, in very large series of cases, a mortality of rather less than 2 per cent. That is a very wide difference, and depends, I think, partly on the fact that Dr. Campbell's figures are a collection from a number of different operators and partly, and more largely on certain facts which I want to bring before you.

I think it is fundamental that if a surgeon is to be called upon at any stage of a given disease to undertake surgical treatment, and consequently responsibility for the result, that he should be asked to see the case early, and should be given an equal voice in consultation with the physician as to *when* his intervention is to take place. In exophthalmic goitre the great proportion of surgical fatalities occur because surgery is undertaken at the wrong moment. These cases should never be operated on during a crisis. If they have diarrhœa or vomiting, if their weight is rapidly going down, or if they have acute cardiac symptoms they are not in a fit state for surgery. They are medical again, and must be coaxed by medical means past their crisis before being operated on. Too often the surgeon is only asked to operate when they have reached a crisis, and just as you cannot expect a small mortality if you wait for an appendix to get peritonitis or for an ulcer to perforate, so, in such a case, the mortality will be high. I do not think, except in acute cases, that operation is often called for in the first three or four months, but I believe strongly that if at the

end of that time symptoms are still progressing, that that is the ideal time for operation, before the first height in the disease has been reached, and before any permanent damage has been done to the systems. At this stage thyroidectomy can usually be safely performed at one sitting, and the disease can be cut short. If the patient is not seen until later, as must very often be the case, it is most important to enquire carefully into the history so as to thoroughly orientate yourself as to what stage in the course of the disease you are dealing with, and further to watch the patient for a time to ascertain whether her condition is on the down or the up grade. If the former, careful treatment will often produce considerable betterment, and make operation safer, and in any case of severity, or of doubt, it is wise to tie one superior pole of the gland first, so as to have a test of the patient's reactions and the degree of the toxicity. A temporary improvement usually occurs, and thyroidectomy, which in the first place might have been fatal, can be safely carried out as a secondary operation in one or two months time.

Next in importance to when to operate comes the question of what to do, and here I think the surgeon finds his greatest difficulties.

In the first place, it is a very good rule when there is any doubt about a case, always to do a preliminary ligation. It is a minor operation, a matter of a moment or two, and gives the most valuable indications as to the future management of the case.

Secondly, it is important ultimately to remove enough of the gland to cure, and not only to ameliorate the condition. A great many surgical results are improvements and not cures, and this, I think, depends mainly upon how much gland is removed. Just how much should be removed depends upon the severity of the case, but in a well-established exophthalmic goitre it is, I think, seldom enough to remove only one lobe as is so often done. It may or may not be possible to remove sufficient gland at one sitting, but if it is not, there should be no hesitation in advising further removal later if a cure is to be obtained.

I have not time to-day to discuss with you the details of technique and treatment, but what I do wish to lay stress on is the fact that exophthalmic goitre is a medico-surgical disease, and to ask that if surgery is to have its fair opportunity, that the surgeon should be taken into the discussion early, and not be left out until his best opportunities are gone, and he is faced with a patient who has already passed through the stages where surgery would have been her best hope.

Voices from the Past.

Ne forte credas interitura . . . .
Longe sonantem . . . .
Non ante vulgatas . . . .
Verba loquor. —Hor.

(*Continued.*)

Memoriæ Technicæ.

I am not prepared to answer definitely the question as to whether the use of artificial aids in learning Anatomy was approved by the Lecturers and Demonstrators of those days or not.

It is a mixed question, and depends whether they were reserved for special difficulties, or otherwise. To trust, or attempt to trust, to "tips" and tricks in learning the broad facts of anatomy, is absurd; but for keeping together, or in proper order, facts which have little or no natural cohesion in themselves, they are sometimes useful. They are a cement for sticking things together, not to be used in the place of brick and stone.

In Anatomy.

A knowledge of anatomy must be obtained, as a student acquires his knowledge of the Borough, and that is by frequent use of its roads and streets. There are places in London one is not permitted to enter, so there are parts which one cannot dissect.

I would give as an instance, the course and branches of the internal maxillary artery. The division into three parts is quite artificial, and without any practical importance. So are the names and exact order of its branches; but inasmuch as they are sometimes required they must be learnt. Any method of committing this to memory is justifiable, and cannot be met by any valid objection. For this, as well as others similar, I made for my own use a triplet of elegiacs, the words of which were bound to follow each other in proper order, or they would not scan. I remember this jingle even now. But it is another story

with regard to any plain and important surgical part, such as the Popliteal Space, which ought to be as familiar to a surgeon as the rooms of his house. Yet I remember once, at a demonstration, we were told that it was a common thing for men up at the College, to give the order wrong. "The word 'Neva' will prevent you doing this," said the demonstrator, "but I don't know what the E is for." He was evidently not a man who relied much on "tips," for the "E" is the keynote of the word:—Nerve, External, Vein, Artery.

In Medicine.

We used to be reminded that another very common error, made at the "Second Coll." was to give, "Swelling and Pulsation," as the two prominent factors, or physical signs, in Aneurism of the Arch of the Aorta. It is not to be denied but that these symptoms may supervene, but it is only after the disease has existed some time.

In an early number of the Gazette, there may be found a short poem which is easily learnt, and was written to prevent this awkward mistake being made. I forget the title, but it begins, "The Spring is coming on us fast." How often I have heard those verses quoted since.

In Materia Medica.

An excellent Guy's man of my day was once asked, "Into what preparation of the Pharmacopœia does Sassafras enter? I was close to him as he laughed merrily and said, "Sassafras, sassafras, where do you go? Into Decoctum Sarsæ Co." This is a fact, for I heard him say it. I have already spoken of "Splashing" as a symptom in pleuritic effusion. These examples show the extent to which no objection was ever offered to the use of Mem. Tech. They are, briefly—

To avoid common blunders.

To preserve the proper sequence and order of facts which are difficult to keep together by other means.

To assist the memory in retaining small unimportant facts, for a time.

To ensure the accuracy of important facts.

Society of Apothecaries.

It may interest some of the younger readers if I relate an incident relative to the Society of Apothecaries' Examination. From one point of view this is a very important qualification to obtain. It may not be generally known, but it is nevertheless a fact, that a medical practitioner cannot legally recover charges for medicines supplied unless he holds the diploma of this body. To a man, therefore, who intends practising in the country it may be an essential. That was the idea which lay in my mind when I presented myself. The County Court Judge of a certain provincial town was on very bad terms with one of the doctors of the district, who supplied his own medicines. As there was some suggestion of his taking me as a partner in the future, I was instructed to try and get the qualification, for the County Court Judge was very strict on the point and struck off all charges for drugs unless the medical attendant was L.S.A.

In those days the final examination was, in some ways, a grotesque affair. The examiners were mostly elderly practitioners, who were in one way or another connected with the Society. Some of these had long ago forgotten some of the things that they had learnt. In these cases a little furbishing up, preliminary to their appearance as examiners, was necessary. The uncle of a friend of mine said that he found it necessary to run over a chapter or two of Steggall's Manual. It was most dangerous being examined by such men. They knew the one answer and that only.

An Examination Anecdote.

I was asked by one to "describe the action of nitric acid on uric acid." "Come now," I said to myself, "we are getting on, I think I can do this pretty well." However, the answer I gave to his question fell on unappreciative ears, and when I wound up with "If the urine is concentrated, it will precipitate it." I was met with a flat denial. "Nothing of the kind, nothing of the sort, you are quite wrong," he said. "But I am sure of it" I replied. "No. No. Nothing of the kind. You quite wrong, quite wrong." "I am quite sure I am not," I persisted, "for we are told so in our lectures by Owen Rees, and he is a good clinical chemist, and it is several times mentioned by Dr. Golding-Bird in his book on the urine."

"Have you never read of the murexide test?" he said, as he held a nicely mounted slide in his hand. Putting this under the microscope,

he bade me look at it, and walked away. Soon he came back with a younger man, and said to him, as he indicated me, "This gentleman says that nitric acid precipitates uric acid, what do you say?" "In concentrated urine," I added. The visitor looked on the ground, and nursing his elbow and pinching up his bottom lip between finger and thumb, walked away. "Ah, well," my obstinate examiner said, "In future, when you are asked, say it forms murexide crystals." This was his knowledge, and all he knew of the matter evidently.

Botany.

Another thing which was essential at that period was to know the distinctive features of all the principal natural orders. One was given in every paper, and it was understood that the correct answering of this question was looked upon as a very important item.

As learning Botany always seemed to me a mere waste of time, which ought to have been given to more important things, I resented the drudgery which this Natural Order question necessitated. After a little thought I resolved on a good plan. I converted all the principal Orders into rhyming doggerell, which was easily construed into botanical idiom. The more important the order, the longer the rhymes. The day of examination came, and the papers were given out. First I looked for the Natural Order question. It was "Rosaceæ," one of the most important. "Before I get confused with the rest of the questions, I will write out my poetry," I thought to myself. So I did. It filled a sheet of foolscap. I laid it on one side till its turn came, and set to work on No. 1 question.

During the writing of the paper one of the examiners patrolled the room, looking, now and then, over the shoulders of the writers, and peering at their penmanship. He came to me, and taking up my rhymes, evidently thought I was going to send them in like that. He must have been a bit of a sportsman, for he only said, "You shouldn't trifle with your questions like that."

In proper time I put it into proper phraseology and sent the papers in. Then, as we sat waiting for the *viva*, in came our late sentinel. Coming up to me, he said "You have written the best paper in the room." Evidently my Nat. Order question, having given every fact correctly, had had great weight, and had been sufficient in itself to neutralise my poor performance afterwards.

Be that as it may; if these old gentlemen were benevolent and kind-hearted, and seldom rejected a candidate, it was said to be dangerous to differ from some of them on their pet theories when they had been already irritated by a previous circumstance.

Houses and Residents of Front Quad.

(Mr. Stocker, The Chaplain, The Matron.)

I am not very well acquainted with the duties discharged in those days by Mr. Stocker. He was described on the prospectus as "The Apothecary." He may have been responsible for the drug department, and controlled the dispensing of medicine, but I never saw him engaged in the dispensing department. He was looked upon more as a survival of a past régime, having outlived the old order of things and been promoted to more genial and lighter duties, more in connection with the School. His office was in the centre of the Medical Building, opposite to the Anatomical Theatre, and it was to him we went to pay our fees, and put down our names for parts, etc. He also was the intermediary between the students and the hospital exams.

He was a very bland old gentleman, and was always about the hospital, and up and down the colonnade. Slow of speech and impressive in manner, he was quick to appreciate the fun of a thing, and dearly loved to be consulted by men in their little difficulties. In short, he had a very kind, fatherly manner. It was to him I went when I held my first appointment as Surgical Ward Clerk. Small-pox was prevalent at the time in London, and I was in doubt about a rash on a man who had been admitted for an accident He had a very pronounced rash on his upper chest and shoulders, and, apart from his contusions, etc., was evidently not well. I compared the appearance of the spots with the description of the eruption of small-pox given in text-books, and thought it corresponded exactly. I asked old Stocker if he would come and look at it. He did so, and asked the man if he had been rubbing his chest with any liniment. He confessed that he had done so previous to coming into hospital. The old man turned to me, smiled, and said, "The man has got bronchitis, and has been using croton oil liniment."

He lived in the end house next the street, on the chapel side of the front quad. I am not sure whether the chaplain did not also have a portion of the corner. Between the chapel and the wards was the matron's house.

The Treasurer.

On the other side of the quad, next the street, lived the Treasurer, the autocrat of the hospital. He was reported to have plenary jurisdiction over the whole of the affairs of the hospital. He even appointed, and had power, if he chose to exercise it, to dismiss the Staff. It was to him every week that the H.S. and H.P. took their reports, which he went through with a rapid mumble, initialed, and, perhaps, though very rarely, asked a question about, and rapidly dismissed. He usually attended the first meeting of the Physical Society and made a short speech. His name was Turner, and he had a very venerable look, due to a large shock of rough, long white hair. He was a very reserved man, and was seldom seen about. His son was a student at the hospital, entering about 1867. I used to think it strange that a man holding such great authority should care to live in a dingy back street like St. Thomas's.

He was succeeded, I think, by Mr. Lushington, who inaugurated, with the Matron, the change in the nursing arrangements which gave such offence to the Staff.

Dr. Steele.

Next to the Treasurer's House was the Counting House, and between that and the "Rooms" for the residents was the house of Dr. Steele, the Superintendent. With him we had little or nothing to do. He was not concerned in the Medical School. There was no Dean or Warden in those days.

Dress and Fashion.

I suppose now, as fifty years ago, the centre of Hospital life is the Colonnade. Here was to be seen the typical medical student of the period. Fifty years is a long stretch of time, and many changes affecting fashion and dress may take place in it. Yet how little is the change in a man's clothing during that period, as compared with the fifty previous years! I remember my father's description of the dress of his youth, and if it were put on to-day and worn, the wearer would be looked on as an imbecile. Beaver hats, high roll coat collar, swallow-tail coat of fine blue, or brown, cloth and brass buttons, knee breeches and silk stockings, shoes, and big buckles sometimes. His collars were so high that they used to make his ears sore. Whereas the last fifty years, except minor alterations of cut and shape, have left men's dress almost unchanged. A man could walk the streets now, as he dressed then, without exciting comment, and vice versa. His hat brim, or the length of his coat tails, might not be quite fashionable, but there is no radical alteration. As I write this there hangs in view a coloured picture of me, taken fifty-five years ago, and I am dressed practically the same as I am now. The linen collar is the same, but some wear rather different ones. The choice being optional. The exact shape does not excite comment.

There were then certain unwritten laws which most men observed, and a non-compliance would have made a man singular amongst professional men and students, but that is all. A Guy's man then always wore a silk hat and a coat with tails; a frock coat preferably, but a morning coat with short tails was quite good. A bowler hat was very rarely seen, and the present day short jacket had not arrived. The only short jacket was of blue pilot cloth; these went about in company with the bowler hat, and the two together were enough to stamp the social merits of the wearer as a poor man, or of inferior position. Better a threadbare frock coat, if well cut, and a silk hat, however seedy, than a blue jacket and bowler hat.

Except in the strictness of this one rule, dress was much as now. I consider this a very remarkable fact, especially when it is considered to what extreme lengths the attire of ladies has gone in the meantime.

In the Sixties was the climax of the crinoline. The circumference of the feminine skirt was enormous. From that fashions rapidly went to such a degree of tightness that the wearers had difficulty in getting upstairs. So strict was the cult of the silk hat, that I remember how it was once the cause of an awkward dilemma.

A Tale of a Silk Hat.

It was on one of those unpleasant occasions, where doctors did not agree, that I had to meet two other doctors and try to get them to adopt a different course. There were also

two legal gentlemen present. The days were beginning to be warm, and most people were trying to make it look more like summer by laying aside their winter garments and putting on apparel more suggestive of sunshine and flowers

As the five of us left our hats in the dining room, the trees outside in the garden were also putting on their new green coats, and all nature seemed about to revel in a new dress.

When our difficulties were settled and we returned to claim our respective hats a new obstacle arose which threatened to be more awkward than those we had just settled. It was this—there our hats lay, side by side, on the polished mahogany, and not one of us could claim his own. They were all new, all Lincoln and Bennett's, and all with white leather and scarlet satin linings. There was not a mark in any by which they could be recognised. The only thing to do was for each to make a selection. Fortunately I was able to recognise mine by the size. It was the biggest. Too big for the other four heads, it was the only one that would fit me. So I was able to leave them to divide the rest as best they could.

Father McDaniell.

My picture of the days gone by would not be complete if I did not include in the scene the short and slightly corpulent figure, and bright merry face of Father McDaniell. He had no official connection with the Hospital, but it was part of his duty, as Parish Priest, to visit those of his own communion who were in-patients. He was personally well known to most of the students, with whom he was a general favourite.

I have nothing but good to say of him. As far as my knowledge of him extended, his influence among the outcast and criminal poor in the Guy's district was very great. His name was known to all. The vilest cellar, and the most secluded den were all familiar with his name. There is no doubt he did his duty as thoroughly as it could be done. I am no Papist, far from it, but I freely confess that the religion of the R.C. Church in the hands of a man of tact and devotion to his cause, is much easier to be grasped and followed, than the highly rectified spirit of us Protestants. The R.C. priest says, "If you do as I tell you I will intercede for you, and my prayers will be heard." It is plainly before them in a tangible form. They see the face of the speaker and he makes their duty easy, simple and formulated. They must say certain words and do certain acts, and then he will see to the rest. It is not satisfactory to a critical mind, but it is so to these poor ignorant people; and this is the reason that the priest's influence was so widespread and effectual.

I remember, once, I was at the top of a short, blind alley, where I had just come out of a dreadful sort of den, where I had been spending the night attending a partus. It was just getting light, and things were not very plainly visible in the early dawn. It was winter, and I was wearing a particularly thick and long ulster overcoat, which I had got specially for the occasion. As I stood putting on my gloves I watched, with some uneasiness, a small group of men who were evidently regarding me. I could easily see that, if they meditated mischief, resistance on my part would be useless, or even dangerous. I would just trust quietly to the respect they had for my work. In a second, all of a sudden, one of the number darted off, and rushed straight towards me. I stood perfectly still and never moved. When he got to within an arm's length from me, he dropped down on his knees on the muddy street, put his hands together and said, "Your blessing, father!" To which I replied, "You have my blessing, my son; go in peace." I left him kneeling in the street. I supposed that he mistook me for the priest, but there may have been more behind it than I knew.

On another occasion I had just finished a most tedious case, in a bare-walled room in one of the most forsaken yards in Kent Street. There had been, throughout the night, some four or five gin-drinking women in and out of the room, having, every now and then, "little drops" of the odious spirit, so that by the time it was all over, they were themselves in high glee. They then put their backs against the door and vowed they would not let me pass until I, too, had "wet the baby's head," that is, drunk it's health.

I begged to be excused, and remonstrated with them, but it was useless. They would not let me go. I had used every argument I could think of, but all were in vain. They swore I should not go till I had drunk. Finally, as a last resort, I said, "Now I know

all of you women, each one of you well. If you do not let me go quietly I shall at once go and fetch Father McDaniell and bring him here, and he shall curse you, and all of you, baby and all, with bell, book and candle. So let me go now, at once." The door flew open as by magic.

That incident shows the influence he had gained, and I could trust him to use it for their good. Differences of doctrine, of infallibility, and bulls, etc., would not enter here, nor transubstantiation, nor auricular confession. He would use his power for their own personal improvement.

I said he was popular with the men of the hospital. They were fond of him. The reason was that he was a man of tact. He said and did the proper thing, in a proper manner, at the right time.

Here is an instance—a difficult one—and one where many would have been carried away by their righteous indignation. At one of the Conversaziones given at the hospital, crowded with guests, one of the older men made what most of us would consider a very rude and disgusting observation to Father McDaniell, seeing that he was a priest under vows. Instead of replying in anger, he said (paying rebukingly a compliment to the offender's University education by speaking in Latin), "Retro me, Satanus," and turned away. This tact and wit of his was much appreciated and his victim felt very small.

(*To be continued.*)

Specialities.

Messrs. THOMAS ARMSTRONG and BROTHER, LTD., Manufacturing Opticians, 79, Deansgate, Manchester, and at London and Liverpool.

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Ophthalmic surgeons about to practice are furnished by this Firm with everything necessary, on terms by arrangement.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR MR. EDITOR,—I want to grumble; I suppose the tactful man would improve his chances of publication by remarks about the powerful influence of your GAZETTE; the very act of writing relieves me—affords an outflow for the black bile—so I don't mind whether it sees the light or no.

I want to grumble about the General Medical Council, which appears to my jaundiced eye as a collection of highly estimable individuals wielding a power over, *inter alios*, the medical students of the day.

The zeal and energy of its members I do not doubt. Unfortunately, the long years that have elapsed since their own junior student days may tend to obscure the result of the policy of adding to the "minimum curriculum" straw after straw.

Some of them are engaged in teaching, but even so they only meet their students at one point; advice too the G.M.C. have no doubt taken from eminent men and teachers in preliminary subjects; but each specialist must see his own particular subject with the widest vision, and the burden of the broadening of learning is the burden of the student's sigh.

There is, I must grant, one great advantage in our present system; anyone, who works "successfully" through the preliminary curriculum of today, ere long acquires the valuable art of jettisoning useless learning, in order to make room for the latter, and "shorter" part of his "course"; can he be blamed if some of his scanty but precious cargo goes overboard with the rubbish.

As a constructive suggestion, might not some enlightened body elect, as its representative on the G.M.C., not the man who "has arrived"—whose recollection of his prelims. is dim in the general roseate hue of his student memories—but a junior, e.g., one of the hospital registrars.

Such a member could speak, not only of his own recent trials, but also of the inability of the average student's mental digestion to deal with the hastily swallowed gobbets of his unending meal.

May I be allowed to add that, as a certain examining board has decided to admit me as "qualified," I am free from being personally worried by this aspect of the G.M.C.'s activities.—I am, yours faithfully.

TUTUS.

August 26th, 1922.

Birth.

STEBBING.—On 8th August, 1922, at Brigown, 20 Telford Avenue, S.W.2, to Margaret Warburton, the wife of George French Stebbing, of Lambeth Infirmary—a son.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE ever-increasing scope and complexity of medical knowledge, and the growing demands of all special branches of medical work have so added to the difficulties of medical education that it is essential, particularly in the preliminary studies of the medical curriculum, to throw overboard all that is unnecessary, and to retain only those parts of our pre-clinical studies which we cannot afford to cast aside.

The letters from our correspondents "Tutus" and "Registrar," which we have published in the last, and in this issue, voice considerable resentment at the present state of affairs as regards medical education and express the opinion that the General Medical Council cannot afford to neglect the views of the "man on the spot," the student who has not yet finished, or who has just finished his course, and whom the defects and merits of the present system of education most immediately affect. The justice of this view must be admitted, although we cannot help feeling, in spite of "Registrar's" opinion, that a man who has not yet passed his final is quite as pre-occupied, quite as lacking in breadth of view, and quite as anxious about the future as any Registrar, so that any adequate representative of the views of the great mass of students would have to be a man who had already qualified.

The new recommendations of the General Medical Council include one which provides for the raising of the minimum age of registration to 17, while at the same time the study of elementary physics and chemistry is to be relegated to the position of a preliminary to registration, to be performed while at school, or just after the matriculation or other examination in general education. After registration the student is to devote himself to General Biology until he has passed an examination in this subject. The course may, if

necessary, be taken before registration, and the examination passed just after.

Having performed this task the student is still confronted with the study of Physics, Chemistry, and Biology in relation to Medicine, and he is to be tested in these subjects by examination.

The minimum length of the course under the altered conditions is 5 years, from registration to qualification, but the course actually, though not formally, is lengthened, owing to the time spent in the study of chemistry and physics before registration.

The most valuable of the Council's recommendations is to the effect that three years shall elapse between the passing of an examination in anatomy and physiology, and the final examination. Although we can well imagine that this provision will lead to some hardship in a few cases, the majority of students will be benefited by an enforced period of clinical study of at least three years.

We should prefer to see more improvements in the direction of elimination of unnecessary preliminary studies, and greater facilities for the study of the final subjects.

Sir Clifford Allbutt, writing in the Educational Number of the *British Medical Journal*, lays stress upon the point that a doctor should possess a general education, a scientific education, and finally a technical education. The scientific part of his education is rather designed to confer a point of view, and a grasp of principles, upon a student, than to make a chemist, or a physicist of him.

The plea for a good general education is irrefutible. No one questions the fact that a doctor, in dealing with the problems he meets in the course of his work, must be a man of breadth and wide outlook, and must, moreover, have an educated mind wherewith to tackle his problems.

No one denies even that a knowledge of the principles, and in some cases the details, of physics, chemistry and biology is essential to the true understanding of human anatomy and physiology.

The complaint of our correspondents appears to be that the tendency has been for too much stress to be laid upon details of science which are not relevant to medicine, by scientific and not medical teachers, and that while "floral diagrams" interest the botanist, and Mendelejeff's Theory of Periodicity delights the chemist, neither has a direct appeal to any medical man, but the researcher.

Nevertheless, if "Tutus'" criticisms of the General Medical Council are based upon a study of the new rule as regards physics and chemistry, we are not inclined to agree with him. It does not appear to be in any way an intolerable burden upon the student, that he should be required to learn physics and chemistry as part of his education at school, and to pass an examination in these subjects before registration. He would probably do that in any case, under modern conditions of education.

We heartily endorse, however, the plea for representation of the men who are most vitally affected by these educational regulations, their spokesman being one who has been but recently freed from the bonds which examinations impose.

THE Rugby season has already begun, and, after the trial games of the week, the first match, against Catford Bridge, takes place to-day.

The First XV. promises to be as good a team as ever. We hope that this year we will succeed in the dual task of defeating both Oxford and Cambridge Universities in

the same season, a feat which we failed to achieve last year, only after a very tough fight with Oxford.

As regards junior players, it is pleasant to note that an extra team is to be run this year—to be known as the Extra "A" XV. Rugger has reached a very high level of popularity at this Hospital. It is a rare occurrence for a single hospital to run five teams at once, and to find fixtures for them all.

It appears that other winter games will also be well supported during the season. We are glad to hear that the Hockey Club have at last heard of a suitable ground. A hockey club without a home ground is in an anomalous position, and for the sake of Hospital hockey it is to be hoped that the Committee will succeed in obtaining it.

We are asked to draw attention to the fact that all Clubs' Union Members are required to show their membership cards before admission to matches at Honor Oak Park. On no account, even at "A" team matches, is the stand accommodation free, and members are asked either to pay their sixpence, or to avoid using the stand on "A" team match days, as otherwise it is difficult to force other spectators to pay for seats in the stand.

Our heartiest congratulations to W. D. Doherty and his bride, who were married not long ago. An account of the wedding will be found elsewhere in this issue. A letter from Doherty, expressing his thanks to the various Guy's Rugby teams which sent messages of congratulation, will be found on the notice board in the Colonnade.

We hope to see Doherty playing for the Rugby team again, during the season.

The Sir William Dunn Chair of Pathology in this School has been filled by the appointment of Adrian Stokes, M.D., Professor of Bacteriology and Preventive Medicine at Trinity College, Dublin. Professor Stokes, who will shortly take up his duties in the School, was educated at Dublin and subsequently worked for sometime in the Rockefeller Institute. He did brilliant work during the war and all who came into contact with him in France were impressed by his energy and initiative. No difficulties, however great, appeared insuperable to him, and his early work on typhoid carriers and his subsequent researches on Weil's Disease and the bacteriology of wounds placed him in the front rank of English Pathologists.

Our readers will join with us in extending a very hearty welcome to Professor Stokes, who will not only be the Head of the Pathology Department, but will also act as the Director of the Post-Mortem Department, and as the Director of the Pathological Section of the Gordon Museum.

The Golf Club.

The second round of the Inter-Hospital Cup, played at the West Kent Golf Club on Sept. 13th, resulted in a win by St. Thomas's by 5½ matches to 3½. St. Thomas's now meet St. Bartholomew's in the final.

St. Thomas's.		Guy's.	
H. Gardiner-Hill (+1) (8 & 6)	1	L. W. Cann (8) ...	0
N. M. Jerram (6) (1 up)	1	K. Hooper (8)... ...	0
R. Taylor-Rea (4) ...	0	F. E. Graham-Bonnalie (12) (4 & 3)	1
R. Sellick (9) (2 & 1)...	1	D. B. Whittock (12) ...	0
H. B. Coverdale (5) (4 & 2)	1	D. G. Bown (12) ...	0
R. W. Robinson (13)...	0	F. James (14) (3 & 2)...	1
	4		2
H. Gardiner-Hill, R. Sellick ...	½	L. W. Cann, F. E. Graham-Bonnalie ...	½
N. M. Jerram, R. Taylor-Rea ...	0	K. Hooper, D. B. Whittock (2 & 1)	1
H. B. Coverdale, R. W. Robinson (3 & 2)	1	D. G. Bown, F. James ...	0
	1½		1½
Total ...	5½	Total ...	3½

Notices.

Royal Naval Dental Service.

An Examination of Candidates for the Royal Naval Dental Service will be held at the Royal Dental Hospital of London, Leicester Square, London, W.C.2, on the 21st November next and the following days.

The number of appointments to be offered for competition will not exceed *nine*.

The Regulations for Entry and the form to be filled up by Candidates will be forwarded on application to the Director General of the Medical Department, 68, Victoria Street, London, S.W.1. The form, accompanied by the necessary documents, should be returned as soon as possible, but not later than the 10th November, 1922.

Candidates must not be under 21 nor over 28 years of age on the day of the commencement of the Competitive Examination, and must possess a registrable degree in Dental Surgery entitling them to practice as Dental Surgeons in Great Britain and Ireland under the Dental Act in Force.

General Nursing Council for England and Wales.

STATE REGISTRATION OF NURSES.

In July, 1921, the Register of Nurses which was set up in accordance with the Nurses Registration Act of 1919, was opened for the enrolment of nurses. After July 14th, 1923, no nurse will be able to put her name upon the Register as an *Existing Nurse* (a) and after July, 1924, no nurse will be able to put her name upon the Register as an *Intermediate Nurse* (b)

But up to July 14th, 1923, any Existing Nurse, and up to July, 1924, any Intermediate Nurse, who wishes to register can do so, provided she complies with certain conditions (which will be found in the regulations laid down by the Council) and pays the prescribed fee.

The attention of those nurses who are eligible for registration, but who have not yet registered, is directed to the following paragraphs.

(1). The Nurses Registration Act has placed the nursing profession on a legal basis, and has given every individual nurse whose name is placed upon the State Registrar a definite legal status.

(2). No nurse will be allowed to call herself a registered nurse unless her name is on the State Register.

(3). Only the nurse whose name is on the State Register will be allowed to wear a certain uniform and badge, and to add certain letters to her name.

(4). Nurses whose names are on the State Register will be protected by law from those who falsely describe themselves as registered nurses, and wear the uniform or badge, or use the letters, without the right to do so.

(5). Nurses whose names are once placed upon the State Register will always remain on the Register (unless removed for felony, misdemeanour or misconduct), provided they pay a very small annual fee.

(6). There is in the Act provision, under certain conditions, for reciprocity of registration with parts of His Majesty's Dominions outside the United Kingdom, without further training or examination. Only those nurses who are on the State Register will be able to take advantage of this provision.

(7). There can be very little doubt that in the future the public will draw a very clear line between the nurse who is State Registered and the nurse who is not. To be registered will be the hall-mark of efficiency of a nurse; not to be registered will be taken as a sign of inferiority.

(8). There can be little doubt also that most, if not all of the various public authorities who employ trained nurses in their service will, in the future, require them to be State Registered.

(9). It is the duty of every nurse eligible for registration to register at once, so that she may take her place in the building up of a great profession. The State has done its duty to the nurses by legalising their position, the nurses must now do their duty to the State by making that position firm and secure. They can help to do that work by enrolling themselves on the State Register.

(10). In December of this year (1922) a new General Nursing Council will be formed, and sixteen of its members will be elected by registered nurses. But only those nurses whose names are on the State Register before October 1st, 1922, will be able to vote for candidates in this election. The General Nursing Council is the body which sets the standard of training and controls the professional education of nurses. It is, therefore, highly advisable that there should be a large number of nurses to take part in the election of the Council.

(11). Nurses can register as general nurses, male nurses, mental nurses, sick children's nurses or fever nurses, according to their qualifications.

For the reasons stated above, therefore, nurses are urged to register at once. After July, 1923, it will

(a) An Existing Nurse means a nurse who has completed her training, or her training and experience, before November 1st, 1919.

(b) An Intermediate Nurse is a nurse who has obtained, after November 1st, 1919, a certificate of not less than three years' training.

be too late to register except by passing the State examination after training in accordance with the Syllabus laid down by the General Nursing Council. Applications should be made to the Registrar, General Nursing Council for England and Wales, 12, York Gate, Regent's Park, N.W.1.

Drawn up and issued by Order of the General Nursing Council for England and Wales, 30th June, 1922.

Ths College of Nursing, Limited.

To College of Nursing Members—

On the Schedule of Application for State Registration (in the appropriate space provided) state that evidence of your training may be obtained from the College of Nursing and give your number. This statement is verified by the General Nursing Council and you are not required to forward your original certificate or a certified copy of the same.

The College of Nursing, Limited.

Established 1916.

7, HENRIETTA STREET, CAVENDISH SQUARE, W.1.

Membership over 21,600.

The College Register represents a powerful voluntary organisation which exists to voice the needs of Trained Nurses through the Council they have themselves elected.

The Members of the College have helped to secure State Registration for Nurses, better economic conditions, an Accident and Illness Insurance, and the Nation's Fund to help the Profession at large.

There are Scottish and Irish Boards, Local Centres, Clubs and Club-rooms, a Rest Home at Bonchurch, Isle of Wight. Scholarships and Grants have been awarded to qualify Members as Sister Tutors, Health Visitors, and Midwives. There is a Loan Fund, Free Legal Advice, a Bulletin issued quarterly, and a College Badge.

Fixture Cards.

Fixture Cards of the Football and Hockey Clubs can be obtained from the members of the various committees, and the College Lodge, price 1s.

(Or on application to the Hon. Sec. of the Rugby Club, enclosing P.O. for 1s. and stamped addressed envelope.)

Will hospital men kindly note the change of address of Mr. W. K. Rist, to 78, Kensington Gardens Square, W.2,

During the forthcoming season the charge for admission to the covered stand will be 2s. on 1st XV. days, the fixtures on September 30th, January 10th, and February 17th excepted, when the charge will be 1s. On the three days mentioned no seats will be reserved.

For other matches Mr. Rist will attend at the Hospital, as usual, before the matches to issue tickets for reserved seats.

On 2nd XV. days the covered stand charge will be 6d.

Clubs' Union members are requested kindly to note that their membership card must be shown at the gate, and that this card does not admit them to the stand for any match.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—I trust that you will assist me to bring the United Hospitals' Winter Sports' Club to the notice of your readers. The Club was founded to encourage winter sports amongst past and present members of recognised Medical Schools. Lord Dawson is the President and much has been done in obtaining facilities for members who wish to spend a winter holiday in Switzerland.

Although the Grand Hotel, Griesalp, in the Bernese Oberland, is the Club Hotel for the coming season, yet advantageous terms are being offered to members by the leading hotels at all other winter sport centres.

It will give me pleasure to send further particulars to any who write me.—Yours sincerely,

JAMES D. LYLE.

Crowland, near Peterborough,
September, 1922.

DEAR SIR,—The recommendation of your correspondent "Tutus" is indeed worthy of our very serious consideration; to me it has long seemed plain. The habit of neglecting to consult the man on the spot is a common fault of governing bodies in general. Possibly the "Old Men" sincerely mistrust the opinions of their juniors; possibly they fear them; their reasons, however interesting, need not concern us for the moment.

In spite of endless discussion, the present condition of medical education is deplorable. So rapidly has medical knowledge advanced of late years that it has manifestly been impossible for all save the very few, whose gifts and opportunities alike are exceptional, to keep in touch with all its roots and branches. Admittedly, the task of reform is colossal; the need is too obvious to labour.

Why, then, continue officially to disregard the views of the one man who can afford direct evidence? True, he lacks experience, but "experience" all too often implies the mere weighing of probabilities and an undue attention to self interests. At any rate, it would not be for him to deliver final judgment.

I would go further than "Tutus," and suggest that his representative should be even younger than a registrar. The average registrar is a pre-occupied individual; he has no breadth of view, and, in anxiously regarding the future, his recent memories are dimmed.

Let us, then, choose a senior student, one about to qualify or very recently qualified, a man of imagination whose horizon is not bounded by the final Conjoint or M.B.; let us give him authority to speak and insist that he be heard, and, at the first sign of fossilisation, let us replace him for the good of the cause.—Yours faithfully,

"REGISTRAR."

3rd September, 1922.

Wedding of W. D. Doherty.

All Guy's men, past and present, will join us in congratulating Mr. W. D. Doherty on his marriage, which was celebrated at St. Michael's Church, Mickleham, on Wednesday September 6th, 1922.

There were a large number of Guy's men among the guests. Rugby Football was well represented, as the marriage ceremony was performed by the father and brother of Mr. C. N. Lowe, who was also present. The duties of "Best Man" were carried out by Mr. E. C. Loudon-Shand, and the majority of the Guy's Football Team were among the guests.

Fortunately the weather was perfect; and over a hundred guests were entertained at a reception and luncheon held in delightful surroundings on the lawns of The Priory at Mickleham. The bride and bridegroom departed by car for an unknown destination amid showers of rice and confetti.

Change of Address.

A. H. Crook, M.Ch., F.R.C.S., 2, Chiswick Place, Eastbourne.

Publications Received.

British Medical Journal, New York State Journal of Medicine, The Medical Journal of S. Africa, The Hospital Gazette, The Nursing Times, Architectural Association Journal, The Hospital and Health Review, The M.S. Journal.

Specialities.

Messrs. F. DAVIDSON & CO.,
Manufacturing Opticians,
29, Great Portland Street, W. 1.

The Micro-Telescope may be described as a perfect combination of the microscope and the telescope by which objects which, on account of their size or shape, cannot be put upon the stage of the microscope can be viewed at any distance between one and three feet from the stage, the magnification varying, according to the distance, between 90 and 30 diameters, with a "field" and "depth of focus" which are very surprising and which are always maintained.

In the study of Biology these features render the instrument particularly valuable, and living specimens may be observed without unduly disturbing them. Sections of many subjects may be studied without the elaborate preparation of slides.

It will be found equally serviceable in photography, the "depth of focus" being always apparent.

Messrs. F. Davidson will be pleased to give a demonstration at the above address to any readers interested, or to furnish full particulars of the Micro-Telescope on application.

Messrs. Wm. Evans & Co. (Hereford & Devon), Ld.
Hereford.

Made from the finest vintage apples in Devonshire, Herefordshire, and Somerset. "Golden Pippin" Cider may claim the first place amongst the many brands obtainable.

This Cider is made solely from pure undiluted apple juice under the best hygienic conditions, and the greatest care is exercised in every stage of its manufacture. A noted feature is its very low content of volatile acidity, a recent analysis giving the percentage as 0·040—certainly a negligible quantity.

Messrs. Wm. Evans & Co., Ltd., will be pleased to send samples to readers on application.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

The Treatment of Pulmonary Tuberculosis.

CLINICAL LECTURE BY DR. GEOFFREY MARSHALL.

GENTLEMEN,—Pulmonary tuberculosis is, as you know, a disease which commonly runs a lengthy course with periods of remission, which in the milder cases may result in temporary or even permanent arrest of the disease. These characteristics make it difficult to gauge the value of treatment, moreover the problem is complicated by the difficulties of early diagnosis and the large number of patients who are consequently treated for a disease which they have not got. Like other common illnesses with a long course, pulmonary tuberculosis is the happy hunting ground of the quack and the faddist. Every two or three years a new remedy is announced with unbridled enthusiasm in the lay press, and unfortunate patients are induced to waste not only their money but also precious time which might have been put to much better use.

Let us first clear the ground by stating that there is no specific remedy for phthisis. We have at our service drugs which will inhibit the growth of some dangerous parasites in the body, for instance the arseno-benzol compounds in infection with the spirochæte of syphilis, emetine in amœbic dysentery, and quinine in malaria. These parasites are higher in the biological scale and therefore more delicate than the tubercle bacillus. Until recently we should have said that there was little hope of finding a drug which would have a comparable effect in tuberculous infections, and that drug has still to be found, but recent developments in the treatment of leprosy entitle us to feel more hopeful of success in the search. The bacillus lepræ has similar staining reactions to the tubercle bacillus, and may therefore be similar bio-chemically. Leonard Rogers and others have reported excellent results from the intravenous injection of chaulmoogra oil and salts of its fatty acid in leprosy. These substances and similar ones derived from cod-liver oil have been tried in tuberculosis, but hitherto their use has not been attended by any striking result. We have treated ten cases in the Tuberculosis Department here with weekly injections of sodium morrhuate over periods varying from ten to eighteen months. Of these ten cases, three have become worse, four are in statu quo, two are greatly improved, and one slight case has become apparently well. These last three patients improved rapidly when the course of injections was instituted; I do not attribute their improvement to any specific action of the sodium morrhuate, I believe it is explained by their faith in the treatment which reduced their anxiety and thereby improved their metabolism. Very few cases of phthisis will improve unless they are hopeful of cure, it is of the utmost importance that you should encourage optimism in your patients, at the same time insisting on rigid observation of rules and precautions which form the main part of the treatment.

TUBERCULIN.

You may have wondered why I said that there was no specific remedy for pulmonary tuberculosis, when many authors describe Tuberculin as such a remedy. The term "specific" should only be applied to a remedy which has a proved selective curative effect on a disease, and tuberculin does not fulfill these requirements. There are scores of different varieties of tuberculin and they have been used on an enormous scale for many years, but there is no proof that any of them exercises a curative effect on tuberculosis. No investigator has succeeded in curing or benefiting a tuberculous animal by tuberculin treatment, nor has anyone cured a primary tuberculous ulcer of the skin by this treatment. On the other hand there are numerous instances of quiescent foci being lit up, with fatal result, by injection of a large dose of tuberculin. Good results are sometimes obtained with tuberculin treatment. These are probably due to the psychic effect, and are not nearly as striking as those reported by Albert Matthieu and Dobrovici with *Antiphymose*. This treatment was given to a group of phthisical patients at the Andral Hospital in Paris. The injections consisted of normal saline solution.

TREATMENT BY REST.

Rest is the main principle of the rational treatment of tuberculous disease. If you observe this principle you can bring about arrest

of the disease in a large proportion of cases of pulmonary tuberculosis, provided you get control of the patient when the disease is in a reasonably early stage.

As soon as you have made your diagnosis you put your patient to bed, and have a record kept of the rectal temperature at intervals of four hours. In most cases the chart will become apyrexial, i.e., will show no reading above 99·6° F. after ten or fourteen days. If pyrexia is still going on after this interval, then the rest must be made "absolute," i.e., the patient must not only stay in bed, but he must stay flat without sitting up, must have only one pillow, must not talk or have visitors, the only relaxation you will allow is books to read. In a small proportion of cases even these measures will be unsuccessful, then you must obtain more complete rest of the diseased parts of the lungs. If the lesions are apical, the upper part of the chest should be immobilised by means of an "apex band," which consists of a strong band of webbing some six inches in width fastened very tightly round the chest under the arms.

When by the above means pyrexia has been abolished, a good start has been made in the treatment. The patient is now rested in bed until he has had twenty-eight days consecutively free from pyrexia. At the end of this time he is allowed to sit up, and every fourth day a further increase of activity is allowed, until in the course of two or three weeks he is walking about for several hours a day. He is now ready to go to a sanatorium where the treatment by graduated exercise will be continued on the lines laid down by Marcus Paterson. Throughout the period of treatment any recurrence of pyrexia is met by a return to rest in bed for a day or two followed by a return to the grade of exercise lower than that at which pyrexia recurred. This treatment requires much patience on the part of the physician, and still more on the part of the patient. It is essential that the patient should have complete confidence in his adviser, the rationale of the treatment must be fully explained to him.

During his stay of three or four months at the sanatorium the patient is trained to observe certain rules which must be followed strictly for several years, and in some particulars for the rest of his life. He will have developed a craving for fresh air which makes it unbearable to stay in an ill-ventilated room, he will be able to tolerate low temperatures and will not wear heavy clothing during the day or night; he will have learnt to rest for half-an-hour before meals, and he will be very moderate in the use of tobacco and alcohol. The patient must be kept under regular observation for some years, any slight recurrence of symptoms will be an indication to increase the amount of rest during the twenty-four hours, and to prescribe one day in bed during each week. If there is a recurrence of activity more severe than can be stopped by these simple measures, then we must immobilise the diseased organ.

Artificial Pneumothorax.

The simplest and safest method of immobilising a diseased lung is to induce an artificial pneumothorax. This operation was first suggested and practised by the Liverpool physiologist James Carson, who performed it on animals just one hundred years ago. It was not until 1894 that it was made use of for therapeutic purposes, when Forlanini, of Pavia, demonstrated its effectiveness in suitable cases. The rationale of the treatment is the same as that of the generally accepted treatment of tuberculous joints, i.e., immobilisation by splints or plaster. When in action, a lung expands and contracts some twelve thousand times a day. If it is the seat of active tuberculous disease it will have a greatly improved chance of healing when immobilised. The indications for this treatment are that the ordinary form of treatment, as described above, should have been tried and have failed, and secondly that the disease should be almost confined to one lung. The results are exceedingly good, not infrequently complete arrest of the disease is obtained where all other forms of treatment are without avail. Collapse of the lung is obtained by the injection of sterile air or nitrogen into the pleural cavity under local anæsthesia, and the collapse is maintained for two or three years by periodic re-injections. The technique is simple and can be seen in the Tuberculosis Out-Patient Department. Those of you who attended a clinical lecture I gave this time last year will remember a tall well-built seaman on whom we had just commenced this treatment. He had extensive signs in the upper half of the right lung, tubercle bacilli in the sputum, and pyrexia which persisted in spite

of prolonged rest in bed. His pyrexia was abolished after ten days treatment by artificial pneumothorax. He refused to go to a sanatorium. He has been working without interruption during the past six months, stoking the furnace of a factory, and he is still apyrexial and has put on more than a stone in weight.

There are a number of cases in which, although the disease is practically unilateral, pneumothorax cannot be induced because the pleural cavity has been obliterated by numerous adhesions, with these and with other advanced cases we must deal on another occasion.

Voices from the Past.

(*Continued.*)

BOB SAWYER.

Amongst the students attending a hospital may be found all sorts, and it used to seem astonishing how, gradually in the course of time, hospital society grouped itself into little sets. One saw a diminishing amount of members of other sets than one's own in proportion as their views and tastes became more divergent.

It will have been gathered from these glimpses into the past that there was a group of men who seemed to think that they had been sent there to waste their own time and their parent's money. Their number was never large, or sufficient to affect the general character, but enough sometimes to be demonstrable.

I remember that once on entering the Theatre, before the commencement of one of the lectures on medicine by Owen Rees, I noticed some sheets of paper lying on the floor of the Theatre where he would stand to lecture. Beyond noticing the fact that there was something white on the ground, the matter did not attract any attention. But it appeared that a small number of men, thinking that the term "medical student" was synonymous with that of "blackguard," and conceiving it thereby to be their duty at all times to indulge in horse-play and senseless practical jokes, had placed these papers in position. I never saw them, but gathered afterwards they contained pictures offensive to the lecturer. Had it been suspected that they had been put there in the way they had been, they would have been very quickly taken up. However, there they lay when Owen Rees entered the Theatre to deliver his lecture. For one moment he glanced at the floor, and then simply said, "I will retire, gentlemen, for a few minutes and will return when these papers have been removed." When he re-entered the Theatre, a few minutes afterwards, they were gone, and he commenced his lecture without any further reference, thereby showing that he perfectly understood that it was the work of a small minority, not worth making any fuss about, but meriting only contempt.

This little circumstance, unworthy of record in itself, together with what I have previously mentioned, is all that I saw of the hooliganisms described in the books of Dickens, and must be taken as a reply to the enquiry in various forms as to whether the GAZETTE appeared during the time of "Bob Sawyer" and his friends. I do not think that there ever were such times, but that the "medical student" of Dickens, Albert Smith, and others, was entirely a creature of the imagination, founded on such mild instances of vulgarity as may be met with in all ranks of society, at all times.

I write this after reviewing in my mind not only my own experience, but that of my forebears, which embraces now a period of well nigh one hundred years. I do not include, in these remarks, "Highbury Barn" day. That was an institution like Town and Gown, Plough Monday, and other well-known commemorative days, and it had its origin, I doubt not ,in some historical fact, for it had this distinction from the senseless ruffianism of which I speak, that it was a definite act on a specified day. There was nothing left to the fancy of the moment or the individual. It was all cut and dried.

In the day that the GAZETTE was born the typical "medical student" was the same as he is to-day, a well-educated sensible man, of more than average ability and culture. But there was then, as there is now, and always will be, a percentage of extremes, and just as we see, on the one hand, men who unreasonably sacrifice their proper duty as regards fresh air, variety of mind occupation, exer-

cise, and other necessities of the healthy body, so are there others who neglect the culture of their mind and debase, what ought to be healthy exercise at proper times, into senseless animal pleasure at every opportunity.

The Nursing Staff.

It was, I think, in '75 that the change was made from the old style of nursing to that which has since become prevalent. It was a great pity that the then Treasurer acted so autocratically and entirely without the slightest regard to the approval or otherwise of the Staff. New brooms sweep clean. The accidental election at about the same time of a new Matron and new Treasurer gave rise to this unfortunate occurrence. There can be no doubt that a change was needed, but there was no necessity for the whole scheme of the Nursing of the Hospital to be remodelled without any intimation to, or the approval of, the members of the Staff. But this was so. The new Treasurer and newer Matron put their heads together, and all that the surgeons and physicians knew was what they saw in the wards.

I had left the hospital then, but was kept in touch with the prevalent feeling by the letters I received from those concerned. The warm-hearted and impulsive Cooper-Forster was roused to a high state of indignation, and he considered it a personal insult to the whole Staff, and one to which he vowed he would never submit or bring his work into harmony with. On the other hand, the younger men who had recently been appointed Assistant Surgeons or Physicians looked on it in a different light. Howse wrote to me on the subject, and said that although he strongly objected to the course that had been taken, he could not afford to throw away the whole of his future prospects in life for the sake of the sympathy which he had with the feelings of his colleagues. The Treasurer was implacable and would listen to no modification. He and the Matron had arranged the nursing of the hospital on a new plan and those who objected to work in harmony with that plan could leave and make room for others who were more in sympathy with the arrangement.

He even threw out hints about the entire dismissal of the Staff, and the appointment of a new set entirely. This, however, was waived on the plea of the more junior members, and he allowed his indignation to be appeased by the dismissal of the Senior Physician, Dr. Habershon, and the Senior Surgeon, Cooper-Forster. The former bore his luck philosophically, for his period of office had nearly expired; but Forster, or "Cooper," as he was familiarly called, retired growling angrily. Although it made but little difference to his professional position, I have always thought that it was the starting point of his gradually-failing strength which ended ultimately in his death. He was a warm-hearted lovable man, but about as firmly obstinate in his way as the Treasurer himself was in his.

There was much amusement felt at the fact of the meek and saintly Dr. Habershon being selected as the martyr and figurehead representing the animosity existing between the Treasurer and the Physicians. It was a striking contrast to visualise him standing figuratively, with sword and buckler, between his own party and the foe, breathing on them the breath of war and defiance, and the mild-looking gentle physician, standing beside the cot of a child, for a moment, before he goes to the next bed, and saying, "Can you read, my little man?" "Yes, sir." "Then here is a leetle book for you to read," at the same time producing a tract from the breast pocket of his coat.

He frequently pointed out to the students the necessity of recognising that nearly all diseases, in these modern times of high tension, were complicated by "great eeritibeelity of the narvous seestem," and must accordingly be treated by "rest," etc.

It was a great pity that this necessary alteration in the nursing could not have been managed with a little more tact and sympathy. I am quite sure the whole of the Staff would have heartily co-operated in any movement for the improvement in the nursing of the patients, but no body of men could be expected to placidly consent to be put aside for an inferior official to act in a matter which was an essential part of their own duty.

This unseeemly dispute was disastrous for a time to the reputation of the Medical School. Men would not enter where there was such discord among the board of management and the Teaching Staff. Its old rivals gained a double advantage, and for years its reputation was under a cloud. All sorts of rumours were rife and the honoured and beloved name had

to be content with a back seat. However, in time the sore healed and soon lay practically buried in the mists of the dead past. Not only was its old position soon regained, but compensation followed in which it more than regained its premier position, the GAZETTE being proudly able to announce the honours its students had won by publishing results which, I hear, have never been surpassed in the whole history of the Medical School. May it long sustain its honourable position!

ADMINISTRATION OF CHLOROFORM.

The same remark applies to all anæsthetics. If the quality is good, and the administrator competent, there is little or no danger, but if the giver is nervous, or the quality bad, then it is better to plead illness. Under these circumstances never attempt to give an anæsthetic unless a reliable man is at your elbow to assist or advise you in any difficulty. Whilst I knew the GAZETTE there was no instruction at Guy's in the administration of chloroform, etc. It was left to the H.S. to teach the dressers and my instructions were those for a straightforward case :—

"Use the open method. One pad of lint, six inches square. Sprinkle this liberally. Do not let it get dry, and do not let it drip. Keep it constantly in position about half an inch from the lips, nose, e.c. Watch the pupils of the eyes. When the struggling is over, the pupils will contract. As a rule, the patient is now ready. If the pupil *dilates* during *complete* unconsciousness, take off the lint at once. If it dilates after the chloroform has been removed, and there are indications of returning consciousness, give him some more. Don't wait till he comes round or struggles. There are plenty of indications which you will pick up in the Theatre."

I found these simple rules acted well. They were easily understood by the students, and gave them confidence whilst they gained experience of their own. Some preferred to use a cone-shaped inhaler as offering more surface for the chloroform and keeping the lint from obstructing the mouth or nose. Nothing made an extemporised cone better than the GAZETTE, rolled up, and a small opening at the apex. I mean the GAZETTE of the time I speak of, eight pages.

JOSEPH LISTER AND HIS WORK.

Before this the "nurses" were likewise also the scrubbers and cleaners of a ward. As often as not when one went into a ward to dress the cases, the nurse would be found on her hands and knees scrubbing the ward floor, up to the elbows in soapy water. Roughly wiping her hands on her coarse canvas apron, she would bring the lint and bandages, and after laying them down on the bed would resume her washing.

When Lister began groping, in those dark days of septic infection, for light by which he might see the origin of all the "diffuse inflammations" and other infective terrors that lay in wait for the patient with an open wound, men awaited the publication of each number of the *Edinburgh Journal* with great interest. Many were the experiments he tried to keep out "germs." One of the very first was carbolic putty. Carbolic acid in some form or other was the first fixed basis of his researches, and great was the difficulty in after years in substituting more powerful, yet less poisonous, germicides for this first prime favourite.

Carbolic putty was made by first mixing warm liquid carbolic acid with olive oil, then adding this to powdered chalk until a substance of the consistence of thin putty was formed. This was thickly spread on a piece of thin sheet lead or tinfoil and applied to the wound. It was supposed to keep the wound protected from the entrance of germs by keeping out polluted air by means of the thick pad-like proportions of the putty more effectually than the lint and gutta-percha tissue so long in use. It was a very unpleasant thing to use, especially in such cases as amputation of the fingers, and quite ineffectual; but one can trace in it the idea of air filtration now attained by the use of aseptic wool.

It is most interesting to follow, in memory, the paths which Lister took in seeking his great truth. It was no blind advance, but a definite pursuit of what he knew existed, requiring patience and philosophy to discover the reason why each successive experiment failed and what was demanded in its place.

It was a new world, as far as surgery was concerned, into which the GAZETTE was born in those far-off days when Lister had practically solved his difficult problem and reached the goal he had striven for so nobly and so long during those previous years. It was entirely his own work, unaided and unprompted by others; the proud victory was his very own. What a field for the surgeons of the future!

What a vista of possibilities it opened to their view! So immense, that it was only a few could realise the extent.

But even now, in these days, one finds here and there rank heresy. It is not very long ago since a Professor of Surgery in a University wrote me that, "We have almost given up here what is known as Aseptic Surgery. All that is required is ordinary cleanliness." This is a position of danger. It is a regrettable opinion for a teacher to hold. He is standing on thin ice. If he exercises great care and caution it may not give way, but it may do. It is quite an uncalled for piece of bravado, and one having for its only recommendation the love of posing as one in advance of others as a scientific thinker.

Listerism, pure and simple, is, in the minds of the majority of good surgeons, the one true, steady, bright light, and men departing on insufficient and personal grounds from its plain truths are just as much opposed to true progress as the old grey-beard still operating in a cloud of steam, with his hands and arms blistered by carbolic acid, or his mouth, nose, and unwashed head tied up in cotton wool and bandage; for they all alike show a non-recognition of what lies at the foundation of Lister's discovery, viz., simplicity and truth.

Opposition to Antiseptic Surgery.

The majority of the older surgeons did not realise its magnitude and its far-reaching results. In short, they thought it a "fad" only, and not to be entertained seriously. Truly, it was then only in its infancy, and somewhat cumbersome and unwieldy in its swaddling clothes, so that it did not appeal as yet very powerfully to surgeons who, all their lives, had been aiming only at neatness and precision.

The idea had to grow, but by the time the Gazette was out of its infancy, the antiseptic system had thoroughly established itself, and was well started on its way to its maturity of aseptic surgery. But so powerfully had the minds of those surgeons who had adopted it been impressed by its superiority over the old septic methods that some of the pioneers of Listerism refused to change from antisepsis to asepsis, and were as obstinate in their obduracy as were ever their seniors who remained "septic surgeons" to the end. All honour to Lister, all honour and success to his contemporary, the Guy's Hospital Gazette, for it was practically about the date of the issue of the first number that Listerism broke from its chrysalis life of experiment to that of a practical and useful life. May they march hand in hand together to even greater things.

War Surgery.

It was very interesting during the great war to read the accounts of some of the young surgeons at the front and their reports of septic outbreaks, and the fantastic names they gave to some of the remarkable infective inflammations they saw there for the first time. They had evidently been educated entirely in the rigidly aseptic days. The frightful ravages of hospital gangrene and infective periostitis, septic phlebitis, and a host of other hospitalisms were matters previously utterly unknown to them. I was much amused when a correspondent wrote that he thought a little course of reading of Ambrose Paré's War surgery in the Napoleonic days would broaden their ideas considerably, or even later writers than that. The first numbers of the Gazette travelling in the pockets of the dressers for the week, even when it was a year old, could have pointed out cases in plenty in Job and Luke and other wards exactly similar to what was such a novelty to these young war surgeons.

Erysipelas.

But these infective epidemics were in those days nearly always called "erysipelas." They were supposed to be removed to "Samaritan" Ward, in the top story, as soon as they were observed. I remember when H.S. going round "Charity" one Saturday; it was Cooper-Forster's female ward, and noticing the red swollen edges of one of the wounds, told sister to have the case removed at once. Next day it was still there and three or four more of the other cases were similarly infected. She said her instructions were that the H.S. had no power to change patients from one ward to another without the sanction of Dr. Steele, the Superintendent. It was his prerogative entirely. She had gone to acquaint Dr. Steele immediately on receiving my instructions, but he was not at home, so she had not removed the patient. She went the next day and he was still away. When I went round again on Monday the cases were still there and many others were also infected. By the time that Cooper-Forster came in the afternoon his ward was practically

full of erysipelas. As I have before remarked, he was a warm-hearted, hot-tempered man, and when he came to the first bedside and found one of his operation wounds in full blast of erysipelas, he looked at me in astonishment and said, "How is it, Mr. House-Surgeon, that this case has not been removed?" "Sister refused to do so," I replied. "I noticed the first case two days ago and ordered its immediate removal. Sister has persistently denied my authority to order her to change the ward, and now it is nearly full of infective high temperatures." He then turned to Sister, who replied that Dr. Steele had told her she must never shift a patient without his consent. She had gone to him each day, and he was absent during the whole time. She was only carrying out his instructions. I added, "I think, sir, the House Surgeons ought to have power to remove these cases without waiting for permission from Dr. Steele." "Ought to, and *shall have*," yelled the furious Forster, and forthwith bolted into Dr. Steele's office, leaving us in a state of wonder. By the duration of his stay there, it was clear that Dr. Steele had at length returned. We never more had any difficulty in securing the removal of a septic case from a clean ward.

That is nearly fifty years ago; I can see now in my mind's eye the rosy apple cheeks of our Medical Superintendent, with a green-covered book under his arm going his rounds, with shuffling feet and listless air, turning his quid round and round in his mouth. I never remember seeing him without his accustomed solace, so that he must have got through a fair amount. We often speculated as to the quantity he took. Was it the ordinary Compound Soap Pill of the B.P.? or did he make them himself and leave out the soap? Whatever time of the day it was one could never meet or speak to him but he was rolling his little quid around and around.

He lived in the house in the front quad. between the counting house and the main body of the hospital. Indeed, the Dressers' Rooms were a part of his house, but disconnected.

Simpson and Chloroform.

It is a far cry to compare the days of Burke and Hare, of which I have previously written, with the present day, or even with the early years of the Gazette, but it may be interesting to compare some of the more noteworthy features. In the first place there were no anæsthetics; at any rate, it was not until some years later that Simpson gave the result of his chloroform experience to the world. So sure was he of the soundness and safety of his discovery that he formulated his maxim, which is still existent now and is as true to-day as it was then, "Good chloroform and plenty of it." If to this he had added "fresh air" it would, I think, have been perfect. "Good chloroform and plenty of it with plenty of fresh air." Most of the ill effects I have seen have arisen from the patient being starved for oxygen. This may be due to either his own defective breathing or the limitation of possibilities of intake by the administrator. A good pad of clean lint., well sprinkled, and free deep breathing with careful attention to the state of the pupil and the body reflexes constitutes as good a rule as I know, and much better and safer than complicated inhalers.

I have not mentioned ether and other anæsthetics as they are outside the experience of the Gazette. Ether was never very popular in Guy's as it was so very difficult to procure of a high quality, and the heaving and sickness that invariably accompanied its administration were complications not to be encouraged. When I was Assistant in the Eye Wards, by some means or other Mr. Bader had got a Winchester quart of ether sent over from the United States. This was quite a different thing. It was pleasant to take and free from all the unpleasantness of English ether. There was no vomiting and no straining, and never, as far as I can remember, any escape of the vitreous, as would have been certain with English ether.

Ethyl Chloride.

We could get no more, so fell back on Ethyl Chloride. This was excellent; the patient was soon under and soon round again. I know nothing better for short operations. It had a reputation of being dangerous, but I gave it many times and never saw any awkward signs. It requires giving bravely and boldly; the patient is then under in 40 or 45 seconds' close application of a piece of lint six inches square. I did not keep taking it off and on. When the patient was fully under I took off the lint entirely and stood back. There must be no nervous fiddling. Then I found it quite safe.

Robert Liston and Syme.

It was the day, too, of "Robert Liston, the great operator," who was always spoken of in

these terms. I never remember hearing an Edinburgh man say simply "Liston," or "Robert Liston." It was always the whole formula. Syme was his rival and his antitype in many ways. Both were great men, but Liston far outshone Syme. Syme knew it, and was jealous. He was also an imitator, and it was these two facts which caused the pupils of that time to regard Syme as being rather narrow-minded as regards his personal endowments.

He always wore a suit of reddish-brown cloth—"small clothes" of fine quality. He advised his pupils (in the course of his teaching) to follow his example as that colour did not show blood stains.

He was the inventor of what is known as "Syme's amputation." It is plain to see the reason why the text-books of those days were so full of "set" operations. It was not then, as now, possible for a surgeon to do a big operation leisurely and carefully, examining each part as he removed it, and following the indication he saw for each subsequent step. There being no anæsthetic, and the patient consequently feeling the full pain of every touch of the knife, the two watchwords of the operator were efficiency of result and quickness of procedure. Therefore each tried to find out the quickest possible route by which he could attain the desired end. Hence we find definite lines of incision and precise directions to the student laid down by eminent surgeons such as Syme, Pirogoff, Chopart, etc. All these different methods were required accurately by examiners.

Another point also there is to-day. The question of mechanical appliances for the use of those who had lost parts of a limb; and this must be taken into account in all amputations and resections. The broad rule of saving as much as possible, sawing the bone as remote from the trunk as possible, amputation *through* a joint when possible, etc., are no longer golden rules in surgery. They are things now *not* to be done. It used to be considered a great help to a man to have his leg removed *through* the knee-joint. Now it is a distinct disadvantage. If an artificial leg is required by one who has had such an amputation, the leg on the side affected would be most unsymmetrical, as the knee-joint of one side would protrude about six inches beyond that of the other on sitting down, looking most inartistic and clumsy. Amputate four or even six inches above the joint and he will have a useful artificial leg and knee exactly matching the other. I had some years ago a long talk on this subject with a very good maker who made artificial limbs of great use and beauty. He gave me many rules of this kind most necessary for an operator to understand if he wishes his patient to be fitted with the very best artificial substitute. He described a "Syme's amputation" at the ankle joint, which used to be considered a test for a quick accurate surgeon, as the very worst form or method of removing the foot. Always go well above the ankle at the junction of the middle or lower third of the leg if you desire a useful, comfortable, and good-looking foot. A "Syme's" means a stiff ankle-joint, even if a foot can be fitted—a great disadvantage.

Did you ever notice the *lateral* play at the ankle as well as the antero-posterior movement? This is of the greatest importance for comfort in walking across a slanting surface. To obtain this in an artificial leg, amputation must be done at the point mentioned.

These are two samples of operating in direct opposition to the above rules in the pre-anæsthetic days, but acutely mindful of the demands of the mechanic.

My old Edinburgh friend said he was once in the Theatre when Liston was about to begin an amputation at the hip-joint. A student pushed him on to a bench that was already full. "There's no room here," said the one crowded. "Go somewhere else." "I shan't," was the reply. "You will," said the other, firmly fixing himself on the bench. He then turned round to watch the operation. It was finished. The leg lay in the sawdust. At the present day we have no conception of the quickness of the "great" surgeons of that period.

Liston was a big strong man, and somewhat rough in his methods. One habit he had of holding the long and bloody knife between his teeth as more quick and ready than laying it down when, for a moment or two, both hands were engaged. This was one of the tricks which Syme imitated, and, being a little dapper man, so different from the burly Liston, it looked most grotesque. On one occasion Liston scratched his hand on the point of the long knife as Syme held it for a moment between his teeth. When Liston felt the pain and saw the blood, he made no more ado, but, grasping

the knife by the handle, wrenched it from between Syme's teeth and flung it to the end of the Theatre. To-day this seems incredible, but the account is strictly accurate.

On another occasion a woman, whose breast he was amputating, screamed loudly. "Be still," cried Liston, holding the bleeding mass he had just removed aloft in his hand as though about to dash it in her face.

(To be continued.)

Reviews.

Dispensing Made Easy. By W. G. Sutherland, M.B.Aberd. 5th edition, revised by A. L. Taylor, Ph.C., M.P.S. (Messrs. John Wright & Sons, Bristol) Price 6s.

As its title indicates, this handbook is intended as a guide to the medical practitioner who dispenses his own medicines. Much useful information has been collected for the man whose object is to save the maximum of both time and money, at the same time ensuring the greatest accuracy. In addition, the author gives upwards of a hundred formulæ culled from the pharmacopœias of thirty odd London hospitals, and many tables of equivalents and solubilities.

Modern Methods of Treating Fractures. By E. W. Hey Groves, M.S., F.R.C.S. 2nd edition. (Messrs. Wright & Sons, Ltd., Bristol.) Price 30s. net.

Mr. Hey Groves has set out in his book his experimental and clinical observations on the treatment of fractures. He rightly refuses to dogmatise on the treatment of any given fracture; each must be individually considered in relation to the various methods of treatment. Some will do best if reduced and given early massage and mobilisation, others need prolonged treatment in more or less complicated splints, and when splinting is unfeasible or has failed, open operation may be necessary.

There is little in the earlier part of the book that any are likely to take exception to, but later on, in dealing with the question of open operation, Mr. Hey Groves' teaching becomes heterodox in the light of the teaching and practice at Guy's. In his opinion the bone-plating operation should in most cases give place to the bone graft. While we agree that physiologically and theoretically the graft is the more likely to do good, yet we have found at Guy's that we get quite as good results, and fewer complications, when we use the bone plate.

The book is rather large for the student who is preparing for the final examinations of the universities or colleges, but he should make himself conversant with some of its later chapters, especially with that one on the treatment of compound fractures. For those, however, who are working for higher examinations, we have no hesitation in recommending this work in its entirety. They will find it full of interesting and useful facts on the experimental work on, and operative and manipulative technique of, the treatment of fractures.

Lawn Tennis Club.

CUP TIES, 1922.

SENIOR.

{M. Jackson. {E. E. Neser. {L. Nurick. {J. Jacobsz. {R. Schlimmer. {Badenhorst.

H. Lewis-Philipps played in place of Badenhorst in the Semi-Final.

JUNIOR.

Winners of the Cup.

{E. V. Potts. {—. Sharpley. {P. Albertijn. {P. Becker. {J. W. Schollum. {A. Gordon.

H. Lewis-Philipps played in the first round, subsequently playing for the first.

F. R. Ratnager played in the final, and V. R. Morgan in the first round.

The Inter-Hospital Challenge Cups.

Senior Cup.

The First VI. lost the Senior Cup, which was won by U.C.H., who beat them in the Semi-Final, and hold the Cup for the first time. The First did exceptionally well, against a team which contained such well-known men as the Brothers Fyzee. It was only after a hard fought game that the Hospital lost by 8—4.

Guy's	Bye	Guy's	U.C.H.	U.C.H.
London	Bye			
St. Thomas's	King's	U.C.H.		
King's College				
U.C.H.	U.C.H.			
St. Mary's				
Royal Dental	Royal Dental	Royal Dental	Bart.'s	
Middlesex				
St. George's	St. George's			
Westminster				
Charing Cross	Bye	St. Bart.'s		
St. Bart.'s	Bye			

Junior Cup.

The Second VI. won the Junior Cup somewhat easily, beating U.C.H. in the Final 12 love.

Royal Dental	Bye	U.C.H.	U.C.H	Guy's
U.C.H.	Bye			
St. Mary's	Middlesex	London		
Middlesex				
London	London			
St. George,s				
Guy's	Guy's	Guy's	Guy's	
Charing Cross				
King's	Bart.'s			
Bart.'s				
Westminster	Bye	St. Thomas's		
St. Thomas's	Bye			

FINAL OF THE LANE-WASHBOURN CUP, 1922.

The Final, which had to be played on two days, owing to rain stopping play after the second set had been started, was won by M. Jackson, who beat L. Nurick.

Nurick started very well, winning the first set at 6—3. The light at this time was very bad, and when the score was 3—1 in Jackson's favour rain stopped play. On resuming two days later, form seems to have been reversed. Jackson played a much better game, continually passing Nurick, who came up to the nets, for shots which allowed Jackson to pass him. Jackson took the second set at 6—3. The final set was more keenly contested, but Jackson proved too good, and won the set at 6—2. This is the third year in succession that Jackson has won this Cup.

The Semi-Finalists were:—
M. Jackson v. —. Sharpley.
L. Nurick v. R. Schlimmer.

WINNERS.

1919—A. C. STRAWBAUM.
1920—M. JACKSON, beat L. Nurick, 6—1, 4—6, 6—3.
1921—M. JACKSON beat E. E. Neser, 6—4, 6—2.
1922—M. JACKSON beat L. Nurick, 3—6, 6—3, 6—2.

RÉSUMÉ 1921—22.

The First VI. have had a fairly successful season. The team, which is perhaps not as strong as last year's, has played some of the strongest teams in, and around, London, in several cases teams whom they have not met before, such as the Navy, to whom they lost only after the score was 4 matches each, set all and 5 games all.

Played 22, won 10, lost 10, scratched 2.

The Second VI., which is possibly a little stronger than last year's, has done fairly well, and although losing badly at the beginning of the season, have won nearly all the later matches. Two very interesting matches were those against the R.A.F., at Wendover, and Emanuel College, Cambridge. Both matches were keenly contested, and only lost by narrow margins.

First VI. Results.

May	9	Gallery	H	...	Lost
,,	13	Ruskin Manor	H	...	Lost
,,	20	Roehampton	H	...	Won
,,	24	Purley Bury	H	...	Lost
,,	27	Dr. Hunt's VI.... ...	H	...	Won
,,	28	Dulwich	A	...	Lost
June	10	Chiswick Park	H	...	Lost
,,	11	Ealing	A	...	Lost
,,	17	Eastbourne	H	...	Won
,,	24	Navy	H	...	Lost
July	1	Eastbourne	A	...	Won
,,	9	Purley Bury	A	...	Won
,,	19	L.C.W. & P. Bank ...	H	...	Won
,,	22	Ealing	H	...	Won
,,	23	Roehampton	A	...	Lost
,,	26	U.C.H.	H	...	Won
,,	27	Sutton	H	...	Lost

Second VI. Results.

May	10	King's College	A	...	Lost
,,	20	R.A.F.	A	...	Lost
,,	24	Emmanuel College ...	A	...	Lost
,,	31	Grafton	A	...	Lost
June	4	Gallery	A	...	Lost
,,	7	King's College	H	...	Won
,,		U.C.H.	A	...	Won
,,	13	Grafton	H	...	Won
,,	18	Nestanglo	A	...	Won
,,	21	Sutton	H	...	Won
,,	24	L.C.W. & P. Bank ...	A	...	Won
July	1	Purley Bury	H	...	Lost
,,	12	Dulwich	H	...	Won
,,	29	Beddington	A	...	Lost

Births.

COOK.—On August 24th, 1922, at Springfield, West Hartlepool, to Vera, the wife of W. Warner Cook, a son.

WACHER.—On August 25th, 1922, at 9, St. George's Place, Canterbury, to Nell, wife of H. Stewart Wacher, M.R.C.S.—a daughter.

Marriages.

CHANNING MATTHEWS—SAUNDERS (nèe Renton).—In August, 1922, at Paris, Ernest Channing Matthews, F.R.M.S., M.I.H., Lieutenant (retired), Regular Army, second son of Thomas S. Matthews, of the Civil Service, to Helen Mary, eldest daughter of the late Brigade Surgeon Lieut.-Colonel David Renton, M.D., 15th Hussars, Barrister-at-law (Inner Temple), and Mrs. Renton.

DOHERTY—BARKER.—At St. Michael's Church, Mickleham, on Wednesday, September 6th, 1922, William David Doherty, son of Mr. W. Doherty, Streatham, to Margaret, daughter of Mr. and Mrs. C. Barker, Mickleham, Surrey.

IDE—PEARCE.—On August 30th, 1922, at the Headless Cross (Redditch) Wesleyan Church, by the Rev. J. A. A. Baker, assisted by the Rev. C. S. Rose, H. Leonard Ide, L.D.S.Eng., youngest son of Mr. and Mrs. Willis A. Ide, of Kingston-on-Thames, to Winifred Mary Pearce, niece of Mrs. J. H. Harper, "Greenheys," Redditch.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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To the Newcomer.

THE approach of October heralds the commencement of a new academic year, and, in accordance with our annual custom, this number of the GAZETTE is a Students' Number, devoted to the welcome and guidance of the Freshman at the beginning of his career.

Two traditional duties devolve upon the Editor of the GAZETTE at this time. The first is congenial, and we are able to perform it without misgivings. In the name of all at this Hospital we extend a hearty welcome to newcomers. They will soon learn to appreciate Guy's and all that membership of the Hospital implies. The second task which custom imposes upon us, that of offering good advice, is one for which we possess but meagre qualifications, and we have, to a great extent, left this responsibility to men whose ability and experience give them greater authority than ours.

Their articles will be found in the succeeding pages of this issue. We will content ourselves with welcoming those who are now about to begin their professional studies here, and, having congratulated them upon their choice of a profession, will confine ourselves to a few general observations upon their future life.

He who adopts the profession of medicine has chosen a fascinating life, though a difficult one. Whatever branch of practice he finally undertakes he will find that he needs energy, self-reliance, and good health if he is to succeed. He will, from the outset, find himself constantly encountering fundamental facts which may militate against his preconceived ideas of life, and as a student he will undergo a constant mental re-adjustment before final stability is attained.

There are some—a few—who are not designed by nature for the medical profession, and for those who are honestly convinced that they are not fitted for the task, the desertion of medicine and the adoption of a more suitable profession will be a wise as well as a courageous step. The life of Keats may be

taken as an outstanding illustration of this fact. But such men must be very few. The fact that a man has started work at a hospital shows the direction in which his tastes lie, and even if he finds at first, that the work is not congenial, he will, in the vast majority of cases, gradually develope an interest in his work which will wax greater as his knowledge progresses. A love of medicine need not necessarily be inborn in a would-be doctor. It may grow upon him, and in time colour his whole existence, just as Bach's music, at first unattractive to some persons, may gradually come to occupy the premier position in their estimation.

Medical education is in a state of transition, one might almost say a state of chaos, at the present moment. It is not likely that it will ever be perfect until the arrival of the millennium abolishes all necessity for doctors. But no system of education can really force anyone to learn. A student may be helped, guided, and inspired by his teachers, but he is the ultimate arbiter of his own fate. If he responds to suggestions, struggles with ideas and does his very best to acquire knowledge and experience, all will be well. If not, the most that books and lectures can do is to confer upon him a limited and superficial grasp of his subject, (and he will quite possibly pass his examinations).

Much has been said lately in medical papers about the relative positions of the pre-clinical and the clinical parts of a student's education. We have before now advanced the point of view that as the great majority of medical students spend their after lives in the practice of clinical arts and sciences as great a portion of their educational career as possible should be devoted to clinical work.

Our correspondent, "E.," in a most instructive, if vehement, letter, which should be read by all, attacks the opinions we have expressed, and emphasises the point of view that as science is the basis of medical knowledge it should be given due prominence in the curriculum. Dr. Nicholson's article on page 394 lays stress on the same point: "The changes that take place in disease must be expressed in terms of Chemistry and Physics. . . ."

The new student possibly will not fully appreciate the pro's and con's of the situation, inasmuch as his horizon is as yet limited. He will at any rate be obliged to cover, for examination purposes, a certain field in the preliminary sciences, and if he is a good man he will become interested and cover a little more than is necessary from the examination point of view. And we should be the last to try to quench his ardour or to limit his work in the pre-clinic subjects. We should rather attempt to whip it up when it flags. But these sciences should be studied "with an eye towards medicine."

The Freshman, to whom this somewhat lengthy editorial is addressed, may stand aghast at this revelation of the demands which, it appears, his work will make upon him, but he need have no fear.

Indeed, he must guard against too strict and unremitting a pursuit of knowledge to the exclusion of other interests. He must not carry his labours to the logical extreme. Oliver Wendell Holmes has remarked that "insanity is the logic of an accurate mind overtaxed," and mental equilibrium cannot be maintained if all work and no play is the order of the day, although work must not be neglected.

The student, before he enters the wards, has many vacations, and, if means permit, he should try to visit some foreign country during one or two of them. He will gain much thereby.

"L'univers est une espèce de livre, dont on n'a lu que la première page quand on n'a vu que son pays."

While at Guy's he will have ample opportunity for indulging in almost any form of sport of which he is fond, and the memory of old comrades in the field, and old games replayed will be among his most cherished possessions when he has left Guy's.

He will meet men from all parts of the Empire, and indeed the world, at the Hospital. As he progresses in his Hospital career he will have to accept more responsibility and he will begin to appreciate more and more the full meaning of the traditions of Guy's. Traditions are not fixed structures incapable of modification. A respect for tradition does not imply a dislike for progress. Joseph Lister fulfilled the highest traditions of the profession when he changed the whole face of surgery by his discoveries. At Guy's a prominent position has always been given to practical clinical work. Guy's men are taught to act promptly in an emergency, to accept responsibilities willingly, and to develope a sound practical knowledge of medicine and surgery.

But the Guy's tradition does not imply a mere apotheosis of common sense. It implies a spirit of investigation, sound knowledge soundly acquired, manual skill, a spirit of willing service—no catalogue of abstract terms could adequately express the meaning of Guy's traditions. They are more appreciated than defined.

If, wherever the present-day students go—South Africa, Canada, New Zealand, India—Harley Street, or an obscure country village, they carry something with them which makes the name of Guy's as loved and respected throughout the world as it is in the Borough—then they will have fulfilled the traditions of the Hospital.

Passim.

THE final Flag Day organised by the Hospitals of London Combined Appeal will take place on October 6th, and we are asked to draw the attention of all students to the notices which are posted in the Colonnade and elsewhere concerning it. Many students and ladies have offered to help, but more are still required, and it is hoped that all who can do so will volunteer to help to make the day a success. Students can not only help themselves, but they can persuade their lady friends to help—and a Guy's student can be very persuasive when he likes.

The Appeal for £500,000 for the Hospitals by the end of the year has so far brought in nearly £320,000. The Prince of Wales, our President, has expressed the hope that the results of the collections on October 6th—"Our Day and the Prince's Day"—will very materially assist in carrying the aggregate result into the last £100,000.

So it is up to Guy's to help.

WE published in our last issue Notices dealing with the State Registration of Nurses, and with some of the activities of the College of Nursing. The Nursing Profession, for long subjected to the worst possible conditions, is at last beginning to be established on a sound basis, and this result may be attributed to the action of the College of Nursing, Ltd.

It is largely through the efforts of this body that State Registration of Nurses has become a fact, and so the position of the properly trained nurse is beginning to receive that respect which has always been its due.

The College of Nursing was established in 1916. The need for some central authority

having a definite educational policy was accentuated at the outbreak of war, when thousands of untrained, partially trained, and trained women were offering their services to nurse the sick and wounded. The College was launched as a purely voluntary body, and its aim is to secure the support of the Governors of Hospital Training Schools, the Matrons and Teachers in these Schools, and the Nursing Profession in General.

The importance of State Registration cannot be over-estimated. The public are sure to differentiate between a nurse who is registered and one who is not, in the future. All Nurses, eligible for registration, are therefore urged to register without delay.

There are obvious advantages attached to State Registration. Those who are, in addition, on the register of the College of Nursing possess far greater advantages. The standards laid down by the College are being adopted in the formation of the curricula of many training schools. Scholarships have been established to enable nurses to qualify as teachers of nursing; free legal advice is given to members of the College; a library of Nursing has been established for their use—in short, the College is doing everything to ameliorate the condition of the nurse and to give greater facilities for her education. The strength of the College Register is now over 21,600.

We have received from Dr. G. Abbott, of Tunbridge Wells, a 6-inch scale map of London (including Guy's) from the Thames to the County goal, "Published as the Act directs," in May, 1799. The map has been presented to the Wills Library, and those who are interested in the changes which have taken place in the Borough in the last century will be able to inspect it on application to the Librarian.

Owing to an unfortunate transposition of paragraphs in column 1, page 383, of our issue of September 16th, those sections of the article on "Voices from the Past" dealing with the Nursing Staff, and with Joseph Lister and his work, which should have been consecutive paragraphs, were separated by one dealing with the administration of chloroform. We owe our contributor an apology for thus spoiling the easy transition from subject to subject which he has always endeavoured to maintain. We also feel that we must make it clear to those of our readers who were struck by the apparent lack of consecutiveness of this part of the article, that the fault lies with us, and not with the author.

A Farewell Dinner was given to Mr. J. Victory on Saturday, September 23rd, prior to his return to Costa Rica. The guests at the dinner were, for the most part, Mr. Victory's more intimate friends, but regret at his departure from the Hospital is general.

Mr. Victory entered the Hospital in October, 1910, and qualified in 1917. Before qualifying he was a student Demonstrator of Anatomy; he subsequently held the positions of H.S. to Sir Alfred Fripp, R.O., R.M.O. Bright, Surgical Registrar from October, 1918, to March, 1919, and R.S.O. for a year or so. He is one of those whom we had the pleasure of congratulating, not long ago, upon their success in the final F.R.C.S. Mr. Victory is a most efficient operator, but we fancy that his popularity was due more to his genial personality, coupled with an intimate association with hospital sport, than to his success in the theatre. The Rugby team loses in him the most enthusiastic supporter it has ever had.

To Dressers and Ward Clerks

By Sir CHARTERS SYMONDS.

"Education is not the acquisition of information. A young man's studies should be wholly directed to the stimulation of his reasoning faculties."

Taking the above as a text, I offer a few remarks for the average student. To acquire real knowledge you must practise independent observation for yourself, using your reasoning faculties. Guidance is needed, and this you will get from your teachers; they will direct your path, indicate where you must delve, but you must employ your own powers. Parrot repitition, mere feats of memory, will not suffice; you must reason for yourself. Such general principles are sufficient for the trained mind, for application to special fields of observation. Such men acquire only an arrow to point the way which they will find for themselves. The majority fail to apply these principles either because the mind is incapable of doing so, or has never been trained in personal observation or "research," to use the favourite expression of the day. Those with outstanding abilities constitute but a small percentage in all professions, the rest require guidance, but everyone can develope the reasoning faculties to a certain degree, for all possess them in some measure. It is to these that my remarks are addressed, in the hope that they may guide to the right acquisition of knowledge.*

The opportunities for the personal care of patients are at present, owing to the number of students, unfortunately somewhat restricted, but still the material available, if properly utilised, will meet this difficulty. You will gain your clinical experience first at the bedside, where you must become a familiar figure; in the post-mortem room, where you will learn the limits of diagnosis; in the operating theatre, where again you see a diagnosis confirmed or reversed. and where you will have the opportunity of studying the parts removed. Then you have the Pathological Museum, where additional examples will throw further light on your cases, and where you will find specimens to illustrate your text-book when you have no clinical example.

In reading you will have a text-book on each subject, and if you have amplified these by a wise use of the means at your disposal, you will need little else. Still, a text-book palls at times, and then let me urge you to look into some of the large monographs. You will get a fuller grasp of your subject, and ample volumes in large print give a sense of relief. For example, every student should look through—indeed, I would like to say *know*—Hutchinson's Illustrations of Clinical Surgery. The life-sized coloured drawings are unique, while the text is crowded with valuable material. An hour on a weary afternoon will be well spent in examining Astley Cooper's two volumes on Hernia. The life-sized drawings of the anatomy of the parts concerned are refreshing after the small illustrations in the text-books. In your reading do not ignore the current literature, especially when you come near the final examinations. The clinical lectures published in the Gazette should be carefully read and noted, and you should begin early to read the medical journals.

To be more precise, let me urge you to make notes of all the cases you see, and all the autopsies, and write these out fully in the evening from the rough pencil notes made during the day; append the remarks made by your teachers and compile a good index, not only of names and subjects, but also of symptoms.

Amplify these records by enquiring of your fellow students for similar cases in the Wards, examine and note these also. In this way you will collect a group of cases and by classifying them obtain a first hand knowledge of disease. Why not form a Ward Clerks' and Dressers' Association for co-operating in this way?

You have let us say a case of congenital heart disease or there is one in the Hospital which you can examine. Go to the museum with your note book, examine and classify all the specimens of this malformation and so with other diseases. Take stricture of the rectum or malignant disease of this part of the bowel; if you will take the trouble to note the age, sex, form of disease, complications and terminations, you will have acquired a sound knowledge of the subject. The record will be followed by your queries, your conclusions. Similarly, investigate any other subject, especially these which time and opportunity have not provided you with clinical examples. This is research in a minor form; you are employing your powers of investigation, your reasoning faculties, and you can all do it

As to autopsies, if a case of your own is to be inspected, you have your notes, to which you will add the findings. When the inspection

*Read Sir Clifford Allbutt's paper, *Brit. Med. Journal*, September 2nd.

is on a case you have not seen, then read the notes made by the clinical clerk, and don't be satisfied with the usual summary. I remember when Dr. Hilton Fagge was Demonstrator of Morbid Anatomy, frequently meeting him in the wards, between nine and ten in the morning, reading the notes of the cases he was to examine the same afternoon. It is an admirable exercise, especially if you write down your diagnosis and your forecast of the morbid appearances. This plan is especially valuable when reading for the higher examinations such as the M.D., as I found myself. It will make you accurate.

Having your cases thus carefully noted and classified, and your books cross indexed and made easy of reference, you will never be at a loss when questioned on a subject studied in this way. You have compiled your own book and of course you know the contents. Reading alone will never do this, nor will teaching by others; you must observe and reason for yourself.

Let me illustrate the value of this method of study as a contrast to reading and listening. One of our students had twice suffered rejection in surgery and came to me for advice. He had read a text-book through several times, and was now engaged on a new book. He had been round the wards, and of course had held the usual appointments: all good and earnest work. Asked to show me his note-books, he replied that so good was his memory that notes were unnecessary. He expressed some surprise when I showed him my student notes made more than forty years before, and still referred to. How could one change such a man's outlook and start him on better lines?

I sent him to the Museum to test his powers of observation. He was to examine and classify some half-dozen groups of specimens in the way I have described above. He brought me an admirable piece of work, and having completed several other similar exercises, I took him to the Museum of the College of Surgeons, and was delighted with the way in which he "read" the specimens He was surprised himself, and said he had obtained an entirely new outlook. You see he had never used his powers of enquiry; they were there all right. The next effort was successful and he was complimented on his pathology. He had, I must admit, a good start, for the first specimen shown him was one we had gone over a few days before.

Out-patients afford an inexhaustable field for observation, and you must note down the essential points in the cases, and enter the progress from week to week. You will become interested in these sufferers apart from their maladies, and learn how many of them live and wonder at it.

In making your notes add diagrams; learn to make readable ones with red and blue pencils. All can do this. Some of you are endowed with the gift of drawing, and if you can add colour all the better. Many possess a camera; use it to record deformities, tumours, facial expressions. In fine, bring every possible aid to your purpose, to acquire by your own effort a knowledge of disease.

Let me conclude this homily by reminding you not to overlook the temperament of your patient, for you will find the same disease cause two people to complain in quite a different way. More especially is this true of diseases of the nervous system and of the heart. Hence the vast importance of seeing all the cases you possibly can, and becoming familiar with the atmosphere which surrounds the sick bed.

In the hope that these few suggestions may help some of you who need such advice, and encourage others, I add my welcome to the new men, and assure them that they have chosen well in coming to Guy's.

The Position of Pathology.

By Dr. G. W. NICHOLSON.

Until after they have passed the second Conjoint or M.B. examination, students often wonder why they have to learn subjects like Chemistry, Physics, Biology, and the *minutiæ* of Anatomy and Physiology. Not until they enter the wards, come into contact with disease, and begin to study Pathology, do they realise the vital importance of these subjects. In dealing with a complicated machine like the human body our observations are bound to be fragmentary and isolated. Much is necessarily left to deduction and the correct interpretation of facts. The changes that take place in disease must be explained in terms of Chemistry and Physics as reactions of the body to alterations of environment. We ever seek to explain the less "exact" sciences in terms of the more

exact ones. Hence it follows that a good scientific education is, and necessarily must be, a progressive one, beginning with the latter and gradually leading up to the former.

If the student grasps the fact that disease is the reaction of the body to changes of environment, he will have acquired an insight into the principles of Pathology. This science deals with nothing that is new. Anatomy and Physiology are the expression of an environment that has been normal; Pathology that of one that has been altered and thereby rendered abnormal. This is Pathology, but it cannot be understood without some knowledge of the agents that set up the abnormal environment, be these contained within the body itself, or be they living or dead substances that have entered it from without. Hence General Pathology is subdivided into Morbid Anatomy and Histology, the study of the alterations of the gross and microscopic structure of the tissues induced by disease, Chemical Pathology, Bacteriology, etc., etc.

Classes and Demonstrations should be diligently attended in all of these subjects, and post-mortem examinations, the most valuable of them all, must never be missed when they concern cases that the student has seen during life. The lure of the wards should not be allowed to interfere with them, for Medicine is merely an application of Pathology and Surgery but too often a confession of failure to grasp its principles. And should the student, at the end of his time at the hospital, realise that he has learnt little more than a mass of facts and how to correlate them, and that he is still as far away as ever from certain knowledge of first principles, the why and the wherefore, his education will have been a sound one, for then he will also realise that his student days will never end.

Publications Received.

Architectural Association Journal, Antiseptic, Current Research in Anæsthesia and Analgesia, British Medical Journal, The Broadway, British Journal of Dermatology and Syphilis, The Hospital Gazette, Indian Medical Record, M.S. Journal, Medical Journal of South Africa, New York State Journal of Medicine, Nursing Times, Prescriber, St. Thomas's Hospital Gazette.

Medical Education in the Pre-Clinical Period.

By Professor C. S. GIBSON.

In previous years, those possessing much more facile pens and greater experience than I have written a few lines of welcome and advice to the medical and dental students at the beginning of their training. A very sincere welcome to Guy's is given them and all the members of the staff express the hope that, during the time of their training and throughout the remainder of their careers, they will always regard Guy's with affection and pride and take their full share of the privileges and responsibilities which membership of Guy's carries with it.

The medical curriculum may be considered to be divided into three stages: viz., (*a*) the study of Biology, Physics and Inorganic Chemistry, and, in some cases Organic Chemistry, which should occupy the first year of three terms, (*b*) the study of the purely medical sciences of Physiology and Anatomy together with Organic Chemistry which should occupy the next five terms, (*c*) the Clinical Period which takes up the remainder of the time before final qualification. Biology, physics and chemistry are included as an integral part of the medical curriculum for several reasons. They afford training in observation and also in inductive and deductive reasoning. The laboratory work is designed not only for giving a practical acquaintance with the subjects themselves but also for developing the dexterity and neatness of working so important in the work of the physician and surgeon. The facts to be learned are probably not so important as the complete understanding of the laws of biology, physics and chemistry without which the study of physiology, anatomy, patholcgy, bacteriology, pharmacology and medicine generally is greatly impeded. The more complete the student's knowledge of the pre-medical sciences the more will he be able to appreciate their bearing on the study of the vital processes in man.

The medical student is frequently urged to pass his first examination as soon as possible, but this does not imply that the subjects in that examination are not important to him in his future work. It is most desirable that the student should not handicap himself by failure in any examination as it comes along, and if it

is realised that biology, physics and chemistry in a medical school are to ensure as complete a knowledge as possible of the vital processes in man, the student will place the correct value on his pre-medical work. Only too frequently have medical men told the writer that they wished they knew more chemistry; they have appreciated the great part that chemistry, especially organic and bio-chemistry is playing in the development of medical science. Certainly, no student can afford to underestimate the value of biology, physics and chemistry to medicine.

The authorities at Guy's have realised the very great importance of the pre-medical subjects to medicine and they are providing greatly improved and increased accommodation for biology, physics and chemistry. With the new accommodation, Guy's will have facilities which no other medical school, as such, possesses. The last thing that is intended is to train men to be biologists, physicists or chemists, but rather to foster greater co-operation between the departments so as to facilitate the progress of medicine.

I have mentioned the importance of passing the various examinations as they come in their ordinary course. It rarely happens that students have any further difficulty when the first examination has been successfully passed and hence it is of the utmost importance that no effort should be spared in passing the first examination at the first attempt. I should like to emphasize the importance of punctual and regular attendance at lectures and laboratory classes. The right to entry to examinations is granted partly on this and partly on the student's mental fitness. Punctual and regular attendance is a wholesome, if trying, discipline and is a useful training for the very hard life which falls to the lot of the conscientious medical man.

After passing the first examination, the student is admitted to the dissecting room and to the physiological laboratories and this is the second stage in his training. Here he comes into contact with the more obviously human part of his subject for the first time and for which he has probably been longing during the previous year. It need scarcely be remarked that the principles of anatomy and physiology can only be mastered by thorough application and continuous industry. The facts of structure and function must be known in a thoroughly practical manner if the student is going to become a successful medical man, and if he does know them he will have no difficulty in passing his second examination and thereby securing his entry to the wards so as to begin, what to him is the most interesting, because it is the most human part of his training. By the time the new student is ready to begin his studies in anatomy and physiology the new anatomical department and the extended physiological department will be in full working order and he will have every reason to be proud of his medical school.

Others will write of the third and last stage of the student's training, viz., the clinical period. The student's work so far has been preparatory for this and, if he has made full use of the opportunities given him, he will be ready to face the responsibilities of the work with which he is now confronted.

Apart from his work there are other important sides to the life of a medical student. As "a Guy's man" he has privileges and responsibilities vitally connected with the corporate life of the place. He should identify himself with the social life by becoming at once an active member of the Clubs' Union, and, although it only falls to the lot of the few to have the honour of representing the Hospital in games, he should play at least one winter and one summer open air game. Apart from the physical and mental benefit gained, more intimate association with other students is secured "on the field" than is possible in the lecture room or laboratory.

I would advise the student to strive to get to know his teachers personally; they will always be ready to make suggestions regarding his reading and may be able to assist him to solve difficulties which arise not only during his training but also in his subsequent work. I would also advise him to cultivate some healthy hobby so that in times of leisure he will have strong personal interests which add so greatly to the joys of living. Finally, I would remind him that the physician or surgeon needs above all to be a man of liberal education. It was Huxley who wrote, "That man, I think, has had a liberal education who has been so trained in youth that his body is the ready servant of his will, and does with ease and pleasure all the work that, as a mechanism, it is capable of; whose intellect is a clear, cold, logic engine, with all its parts of equal strength, and in smooth working order; ready like a steam engine, to be turned to any kind of work, and spin the gossamers as well as forge the anchors of the mind; whose mind is stored with a knowledge of the great and fundamental truths

of nature and of the laws of her operations; one who, no stunted ascetic, is full of life and fire, but whose passions are trained to come to heel by a vigorous will; one who has learned to love all beauty, whether of nature or of art, to hate all vileness, and to respect others as himself."

The student entering the school is fitting himself for his life's work. The responsibilities of the physician and the surgeon are very great, but those who bear them conscientiously are the greatest benefactors to suffering humanity.

To New Dental Students.

By Mr. F. W. PARFITT.

In the name of the Guy's Dental Students from the beginning I offer you our heartiest greetings and congratulations.

We congratulate you on entering our honourable profession. Important changes are taking place in it, and its value in connection with Public Health is being more and more recognised as the years pass on.

You will see the new developments in the coming time, and on you will rest the duty of realising the ideals and fulfilling the hopes of a better order than we have at present.

It is also with the greatest pleasure that we welcome you to Guy's. Our own student days were amongst the happiest of our lives, and yours will be the same.

You will find the atmosphere of Guy's one of constant activity both for work and play, and only the slackers will have a dull time there. As at school, many things are learnt besides those found in books, characters are formed and life-long friendship made. And always there is the great tradition of our venerable Hospital, with its freemasonry of Guy's men all over the world.

We are proud of our tradition of scientific achievement, of public service and of sport. It is, however, no dead thing, but a living and growing spirit, of which all we of the present are the incarnation, and which we must in turn pass on, not indeed unaltered, but we trust undimmed. I assure you that we of the past years envy you exceedingly. Gladly would we have our time over again. How differently some of us think we would use it. Vain idea—we should only be ourselves once more. You, on the other hand, will have all the future to do with as you will, you are the future heads of the profession, the Association Presidents, Teachers and Examiners that are to be, and as such we salute you and shall watch your career with pride.

Pupils' Physical Society.

Re-founded in 1830.

Hon. President.

Sir Charters Symonds, K.B.E., C.B., C.M.G., M.S.

Hon. Vice-Presidents.

Sir William Hale-White, K.B.E., M.D.
Lauriston E. Shaw, M.D.
Sir W. Arbuthnot Lane, Bart., C.B., M.S.
John Fawcett, M.D.

Hon. Secretaries.

J. M. H. Campbell, M.D.
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Presidents.

J. A. Currie.	B. L. Laver.
A. H. Douthwaite.	N. L. Lloyd.
F. E. Graham-Bonnalie.	M. Mackenzie.
R. Hale-White.	E. H. Richards.
M. Jackson.	A. T. Rogers.
T. E. Jones.	M. E. Shaw.

F. W. Widgery.

The Final Meeting of the Session was held on Thursday, 23rd March, 1922, at 8 p.m. The attendance during the session showed that the keenness of the members is gradually regaining the pre-war standard. There is still a lot of room for improvement, and it is hoped that the programme which has been fixed for the next Session will raise the enthusiasm of the ward students. It has proved rather difficult to get men to show cases and specimens, but it is hoped that in the future dressers and ward clerks having interesting cases will bring them forward on their own.

Two meetings of the Society will be held in the afternoon instead of at 8 p.m. as usual so that men may attend more easily. These are the Inaugural Meeting, when Sir Charters Symonds will read a paper on "Some Guy's Surgeons," at 5 p.m., and a Special Meeting, when Dr. Leeson, who was House-Surgeon to Lord Lister, will talk about his memories of Lister at 4.30 p.m. It is specially hoped that men not in the wards will attend these two meetings, and the joint meeting with the Physiological Society.

Last Session the combined Physical and Physiological meeting was a great success, and another fixture has been arranged with the Physical Society of St. Thomas's Hospital, the first to be held at St. Thomas's and the second at Guy's; they will be combined Clinical and Pathological Meetings.

The Society is fortunate in its President and Hon. Vice-Presidents, and in the keen interest they take in its meetings.

The Treasurer's Prize of £5 was not awarded. The Society's Prize of £10 for the best Paper read during the Session was won by Mr. E. H. Richards with a Paper on Toxæmias of Pregnancy. Mr. A. T. Rogers was awarded the Society's Prize of £5 for the member who distinguished himself most in the discussions, and the £5 prize for showing the best Pathological specimens was divided between Mr. J. C. S. Dickenson and Mr. A. W. Hall.

The subject for the Treasurer's Prize Essay, 1922—23, will be "Changes in the Blood in Tuberculosis." The essay is to deal with all or any of the following points:—changes in hæmoglobin, red or white blood cells, or any other organised or chemical bodies present in the blood.

Unfortunately no entries were received for the Treasurer's Prize Essay last year and only one the previous session. In the hopes of attracting more entries the above subject was chosen with the warm approval of the Treasurer by the Committee of the Physical Society, and the choice was confirmed by a General Meeting of the Society. Under these conditions it is hoped that there will be a very large entry, especially as the subject is one which must come under the notice of every member of the Society.

PROGRAMME FOR 1922—1923.

1922.

Oct. 12. Inaugural Meeting at 5 p.m. Address by Sir Charters Symonds, K.B.E., M.S. "Some Guy's Surgeons and their Writings" (with some portraits and other illustrations).
President—Sir William Hale-White, K.B.E., M.D.

„ 19. Clinical Meeting.
President—Mr. A. H. Douthwaite.

Nov. 2. Combined Meeting of the Physiological and Physical Societies. Mr. J. A. Currie and Mr. E. C. Warner will read the opening papers on "Pain."
President—Mr. M. E. Shaw.

„ 9. Special Meeting at 5 p.m. Address by J. R. Leeson, Esq., M.D., on "Some Personal Memories of Lord Lister."
President—Sir Arbuthnot Lane, Bart., C.B., M.S.

„ 16. Pathological Meeting at 8 p.m., followed by a paper by Mr. Spurrell on "Pigments."
President—Mr. M. Mackenzie.

„ 30. Clinical and Pathological Meeting with the Physical Society of St. Thomas' Hospital, at St. Thomas' Hospital.
President—Mr. A. T. Rogers.

Dec. 14. Clinical Meeting.
President—Mr. N. A. Lloyd.

1923.

Jan.— 11. Paper by Mr. L. G. Housden on "Cancer."
President—Mr. E. H. Richards.

„ 25. Clinical and Pathological Meeting with the Physical Society of St. Thomas' Hospital, at Guy's.
President—Mr. B. L. Laver.

Feb. 8. Paper by Mr. E. R. Boland on "Tuberculosis."
President—Mr. R. Hale-White.

„ 22. Clinical Meeting.
President—Mr. F. E. Graham-Bonnalie.

Mar. 8. Pathological Meeting.
President—Mr. J. A. Currie.

„ 22. Special General Meeting and Reading of the Treasurer's Prize Essay.
President—Mr. M. Jackson.

THE TREASURER'S PRIZE.

A Prize of £5 is offered each year by the Treasurer.

Conditions.

1. The Prize is open to every member of the Society, except qualified men of more than two years' standing at the date of the reading of the paper.

2. The papers must be delivered to the Honorary Secretaries by the 28th February, 1921.

3. Each essay must be distinguished by a motto or device, and accompanied by a sealed note, inscribed with the motto or device, and containing the author's name.

4. The essays of the unsuccessful candidates will be returned on application to the Librarian, with the notes that accompany them unopened.

5. The Prize Essay will be read and discussed at the last meeting of the Society.

The subject for each year will be announced at the beginning of the Winter Session.

THE SOCIETY'S PRIZES.

A prize of the value of £10, will be awarded for the best paper read before the Society during the Session; a prize to the value of £5 will be given to the member who distinguishes himself most in the discussions; and a prize to the value of £5 will be given to the member who exhibits the best specimens of scientific interest during the session.

Conditions.

1. No member shall obtain the same prize on two occasions.

2. The judges have the power of dividing the prizes should two of the candidates possess equal merit, or of withholding them should insufficient merit be displayed.

3. Two prizes may not be awarded to the same candidate.

EXHIBITS.

Any members who possess objects of general (not necessarily pathological) interest are requested to communicate with one of the Secretaries, so that these may be shown after the reading of the papers.

D. C.
THEATRE 8
H. Pickard
'22

HOCKEY FIXTURES, 1922—1923.

1st XI.

Date.			Opponents.	Ground.
1922.				
Sept. 30	S	...	Trial	Home
Oct. 4	W	...	Trial	Home
7	S	...	City of London...	Home
11	W	...	Royal Military Academy	Home
14	S	...	Hornsey	Away
18	W	...	Royal Naval College, Greenwich ...	Home
21		...		
28	S	...	Redhill Hockey Club	Away
Nov. 4	S	...	Wallington Hockey Club	Home
8	W	...	Royal Military College	Away
11	S	...	Royal Engineers, Chatham ...	Away
18	S	...	City of London...	Away
22	W	...	Royal Military Academy	Away
25	S	...	Dulwich	Home
Dec. 2	S	...	City of London Mental Hospital ...	Away
9	S	...	Royal Observatory	Home
16	S	...	Spencer	Away
1923.				
Jan. 13	S	...	Royal Engineers, Chatham ...	Home
17	W	...	Royal Naval College, Greenwich ...	Away
20	S	...		
27	S	...	Red Hill Hockey Club	Home
Feb. 3	S	...	Wallington Hockey Club	Away
10	S	...	Malden	Home
14	W	...	Felsted School	Away
17	S	...	Hornsey	Home
24	S	...	Dulwich	Away
Mar. 3	S	...	Malden	Away
10	S	...		
17	S	...	Royal Observatory	Away
24	S	...		

2nd XI.

1922.				
Sept. 30	S	...	Trial	Home
Oct. 4	W	...	Trial	Home
7	S	...		
11	W	...		
14	S	...	Hornsey	Home
18	W	...	St. Bart's. Hospital	Away
21	S	...	King's College Hospital	Away
28	S	...	Redhill	Home
Nov. 4	S	...	Wallington	Away
8	W	...		
11	S	...	Royal Engineers, Chatham	Home
18	S	...	Royal Air Force, Halton	Home
22	W	...		
25	S	...	Dulwich	Away
Dec. 2	S	...	King's College Hospital	Home
9	S	...	Royal Observatory	Away
16	S	...	Spencer...	Home
1923.				
Jan. 13	S	...	Royal Engineers, Chatham	Away
17	W	...		
20	S	...	Nestanglo	Away
27	S	...	Redhill	Away
Feb. 3	S	...	Wallington	Home
10	S	...	Malden	Away
14	W	...		
17	S	...	Hornsey	Away
24	S	...	Dulwich	Home
Mar. 3	S	...	Malden	Home
10	S	...	Royal Air Force (Halton)	Away
17	S	...	Royal Observatory	Home
24	S	...	Burnt Ash	Away

The Pavy Gymnasium.

OFFICERS FOR 1922—1923.

President.—A. W. Ormond, C.B.E., F.R.C.S.

Treasurer.—W. M. Mollison, M.Ch.

Hon. Secretary.—G. V. Lloyd-Williams.

Committee.—Messrs. H. Chapple, M.Ch., F.R.C.S., S. P. Meacock, J. D. S. Thomas, N. M. Holloway, N. L. Lloyd, C. H. Johnson, W. H. Foy.

Representatives to Blues Committee.—Messrs. S. P. Meacock and J. D. S. Thomas.

The Pavy Gymnasium, which is situated within the College, was founded by the late Dr. Pavy, F.R.S., and, during his lifetime, kept up by an allowance made by him. At his death the upkeep and maintenance of the Gymnasium was provided for by a bequest in his Will.

Instruction is given in Boxing, Fencing and Gymnastics, and a hearty welcome is extended to any new students who wish to avail themselves of these facilities.

Boxing Classes are held on Tuesdays, from 5—7 p.m., commencing October 3rd, under Alf. Hewitt.

Gymnastic Classes, on Friday evenings, 4.30—6.30

Fencing Classes, Monday evenings, 4—6 p.m., under Professor Felix Gravé. Prof. Gravé also instructs at his School of Arms, and invites keen men to meet him there for special instruction.

The Gymnasium is available for the use of members between the hours of 8 a.m. and 8 p.m.

There is a shower bath immediately adjoining the Gymnasium with hot and cold water; this is specially for the use of people using the Gymnasium. There are also a number of lockers available for members.

REPORT ON LAST SEASON.

Boxing.

During the last season the chief event was the Inter-Hospital Boxing Competitions, held at The National Sporting Club, on Tuesday, March 7th, 1922, at 8 o'clock. This resulted in a win for Guy's with a score of 22 points, Middlesex and St. George's tieing for second place with 8 points each. The Hospital was represented in each weight with the exception of Fly Weight. One member of the Club made a gallant effort to reduce his weight from 8 stone 12 pounds to 8 stone, the Fly Weight limit, but failed by a couple of pounds.

The team was as follows:—

Bantam Weight.—S. P. Meacock (runner up).
Feather Weight.—C. S. Gross (runner up).
Light Weight.—J. G. S. Thomas (winner).
Welter Weight.—G. V. Lloyd-Williams (winner).
Middle Weight.—H. Trafford (runner up).
Light-heavy Weight.—N. M. Holloway (winner).
Heavy Weight.—R. F. H. Duncan (winner).

It will be seen that every member of the Guy's team reached the final, four winning outright.

Following these Competitions, Messrs. C. S. Gross, J. G. S. Thomas, G. V. Lloyd-Williams and N. M. Holloway were recommended for award of half-blues. A meeting with Oxford University Boxing Club was held at Oxford on November 5th, 1921. The following boxed for the Hospital:—Bantam Weight, S. P. Meacock; Light Weight, F. J. Mayne; Welter Weight, G. V. Lloyd-Williams; Middle Weights, H. Trafford and H. Richards; Light-heavy Weight, N. M. Holloway; Heavy Weight, W. H. Summerskill. S. P. Meacock and W. H. Summerskill won in their weights. Oxford winning by five events to two.

A new event, which it is hoped will become an annual one, was that against The United Insurance Companies Boxing Club, on Monday, February 6th, at The Rifle and Revolver Club, Borers Passage, Bishopsgate, the Hospital winning seven events to five. There were two strings at each weight, and Guy's team was as follows:—

Bantam Weight (first string).—S. P. Meacock. Won.

(Second string).—M. T. Aung. Won.

Feather Weight (First string).—J. D. S. Thomas. Won.

(Second string).—C. S. Gross. Won.

Light Weight (First string).—J. G. S. Thomas. Won.

(Second string).—F. J. Mayne.

Welter Weight (First string).—G. V. Lloyd-Williams. Won.

(Second string).—J. A. Currie. Won.

Middle Weight (First string).—H. Trafford.

(Second string).—B. E. Hawkins.

Heavy Weight (First string).—W. H. Summerskill.

(Second string).—N. M. Holloway.

Sir Arthur Worley presented pewter tankards to the winners.

Alf. Hewitt has again proved an excellent instructor to the club.

Fixtures for Season, 1922—23.—Oxford, November 9th. Others will be announced later.

Gymnastics.

Gymnastics during the past season have suffered severely from lack of support, so much so that although three fixtures had been arranged we were unable to raise teams of six to meet our opponents, and these fixtures had unfortunately to be scratched. What we lacked in numbers we made up, however, in the keenness of the few faithful members who turned up very regularly on practice night, and many other times besides.

It is very unfortunate that the idea seems prevalent that gymnastics is a boy's game and that as soon as one has left school one has put one's gym. days behind one. There are many students in the Hospital who were good gymnasts when at school who are too slack to keep it up now that they have become undergraduates.

There is room, too, for beginners, since it has been our practice to grade the members into two classes, according to their degree of efficiency, and instruction is graded to suit the ability of the individual.

Outside the gymnasium, the only events of interest were the Metropolitan and Southern Counties Championships, for which we entered two members—N. L. Lloyd and C. H. Johnson. The former obtained fourth place in the Amateur Championship, the first three places being taken by members of the Northampton Polytechnic Institute, two of which were members of the last Olympic Games team, while the latter obtained thirteenth place in the Second Grade Championship.

Fencing.

During the past season fencing was adopted as an active sport, after an interval of ten years. True the various teams cannot claim a single victory, but the fact that teams have been formed and matches decided is a sign of good resolution for future seasons. Capt. Gravé, the instructor, is entitled to a full share of praise in so ably instructing the Hospital pupils and also for assistance in arranging matches.

The contest with the Honourable Artillery Company for teams of five a-side at foils was a complete victory for them, the score being 16 matches for the Gunners and nine for the Hospital. In the return match this margin of excellence was reduced to the narrow decision of 13 for them and 12 for the Hospital. They had a stronger second string, but the honour of an undefeated competitor was held by the Hospital, whose captain won all his fights in both competitions.

Harrow School was the next fixture, the match being for foil and sabre. Unfortunately, they were only able to engage teams of two, and more unfortunately the Hospital sabre team was limited to one, who had to meet both opponents without the assistance of a second string. In both contests the School were victors. The match being decided in pool, and Harrow, having the winner of the pool both in sabre and foil, were recorded as winners of both contests. A match is arranged for next season with larger teams.

Oxford University scratched, owing to commencement of term and a change of secretaries, but they are probables for next season, as are also H.A.C., R.M.C. Woolwich, R.A.F., Cambridge University, Gracie's Academy, and other Hospitals, if possessing teams.

Foy and Housden are very fair as a first string, and Spurrell, Johnson, Silvester and Tom, are encouraging as a second string.

A need for sabre men, and also epée exponents, should encourage those who possess any aptitude to take up their instruction so soon as the new season commences.

Rowing Club.

President.—R. Davies-Colley, C.M.G., M.C.
Vice-President.—J. H. Ryffel, M.B., B.C.
Captain.—F. C. Miller.
Hon. Secretary.—R. S. Chambers.
Committee.—Messrs. M. E. Shaw, A. Tom, K. O. Parsons, G. C. Hughes.

The above Club is affiliated with the London Rowing Club, and have the use of their premises, boats, and coaches. The London Rowing Club are allowed the services of Guy's members who are willing to row for them. The entrance fee is £2 2s. to members on joining.

The following resolution was passed by the Blues' Committee in August, 1921:—

> "That not more than four Half Blues be awarded to the Boat Club, annually, provided that there be an Inter-Hospital Race."

The Committee decided to adopt the name of "Guy's Hospital Rowing Club," instead of "Boat Club," in order to avoid confusion with the Boxing Club initials on Half Blue blazers.

RÉSUMÉ, 1921—22.

The Club has made considerable advances during the past year, but unfortunately it has not been found possible to undertake any racing except Inter-Hospital contests. The numerical strength is now about 20. All the new members have been beginners, and by next year should turn into useful oars, under the excellent coaching of Miller, Parsons and Shaw.

Swimming Club.

Annual General Meeting.

The Annual General Meeting of the Swimming Club was held in Classroom I. of the Medical School, at 4.30 p.m. on Thursday, 21st September, the President, Sir Alfred Fripp in the Chair.

The following officers were elected for the Season 1923.

President.—Sir Alfred Fripp, K.C.V.O., C.B.
Captains.—(Water Polo, C. A. Wakeford; Swimming, F. R. Dingle.
Hon. Sec. and Treasurer.—John Simons.
Assist. Hon. Sec.—S. E. Theis.
Committee.—P. G. Harvey, F. G. Hutchinson, R. Scholfield, H. Richards.

Notices.

Exhibition of the Royal Photographic Society.

The following letter has been received by Mr. Bannounah:—

Dear Mr. Bannounah,—

As you are aware the Annual Exhibition of this Society opened on Saturday last and will remain open until the 28th of October. I shall be greatly obliged if you will kindly make it known that we shall be pleased to welcome any of the Members of Guy's Hospital who may be interested in visiting the Exhibition. The Exhibition is open daily from 11 a.m. till 9 p.m., Sundays excepted.

Thanking you in anticipation,
I am, yours sincerely,
H. H. BLACKLOCK,
Secretary.

Our readers are doubtless aware that Mr. Bannounah has done a great deal of work on colour photography. We offer him our congratulations upon the fact that two of his photographs have been accepted for exhibition by the Society. One of them is the first example of a colour photograph of an anatomical specimen exhibited by the Society.

A Day in the Country.

To few collections of men and growing youths does the country make so irresistable an appeal, as to the members of a hospital. Living under conditions that cause degeneration of the body and depression of the soul, the poor, overworked, air-starved, sun-shy invader of the Borough, walks listlessly under the scanty and precarious shade of the plane-trees, listens to the ear-splitting din of the roosting starlings, and pines for the open, rolling downs and the peace of the country-side.

Knowing this and feeling anxious lest the coming generation of medical practitioners should be broken in health even before qualifying, a weekly afternoon in the country has been arranged, almost free of charge, so that at least two hours a week may be enjoyed in the bye-ways of Kent, two hours of bucolic bliss. This is the programme. Taking the 1.58 p.m. train from London Bridge (S.E.& C.R.) to Chislehurst, the party, as merry as crickets, as moral as a Sunday-school outing, will make for the Bull's Head Hotel, one of the most picturesque and comfortably managed country inns in the seven counties. There, after suitable refreshment, the more hardy of the health-seekers will saunter forth on a ramble through the most beautiful scenery. Treading mossy paths, between beech trees, laden with nuts, brambles, buckled with berries, waving bracken and wild rhododendrons, they will fill their lungs with the odour of pine, musk and, at one spot, the gas works, while they take in vitamins in the form of cob nuts and throw the shells at skedaddling cotton-tails. After a round trip of not more than five miles, the party will return to the Inn, where a sumptuous tea—we almost said banquet—will await them. Can you afford to miss all this? If you can, forward your name and we will pray for you. If not, be on the train next Wednesday (October 4th) and spend an afternoon of perfect enjoyment with the United Hospitals' Health Hounds. The fare (cheap ticket) is 1s. 9d. return. ALL HOSPITAL MEN ARE INVITED.

Reflex Signs and Symptoms in Disease of the Hollow Viscera.

CLINICAL LECTURE BY DR. J. A. RYLE.

GENTLEMEN,—The diagnosis of visceral disease as compared with the diagnosis of superficial, muscular, bony, ocular, aural and even nervous lesions seems beset with innumerable difficulties, and yet in the whole of medicine there is no wider and no more fascinating field than that which may best be comprised under the heading of internal medicine. The special difficulties of the subject are not far to seek, for whereas in other branches early changes in structure may be visible or palpable and even changes in function may be objectively demonstrable at an early phase in the illness, in the case of the viscera we have at first and often for long periods to rely for our opinion very largely on the patient's imperfect account of certain subjective symptoms, the very interpretation of many of which remains to this day obscure or inadequate. Direct objective signs of visceral lesions, such as palpable tumours, cardiac murmurs or visible peristalsis we have come to regard as a rule as evidence of advanced trouble, and, as we are unanimous in our belief that methods of early diagnosis must ever be preliminary to the proper understanding and treatment of disease, it behoves us to become familiar with the meaning of as many symptoms and indirect signs as possible.

Numerous accessory methods of diagnosis have in recent years come to our aid, chief among which may be mentioned radiographic and chemical estimations of function in gastro-intestinal affections; electro-cardiographic and other instrumental observations in cardiovascular disease; blood-urea and urea-concentration determinations in renal disease and so on. Vastly, indeed, have these methods improved our diagnosis and illuminated our science and yet they have served, almost inevitably I think, by crowding our curricula and lessening our self-reliance, to impair our powers of clinical observation. Of this we are only too pertinently reminded when we turn for information or refreshment to the writings of some of the great clinicians of the past. The effect of the introduction of these more accurate methods should surely have been, and to a much greater extent will ultimately be, to educate our clinical faculties by enabling us to interpret in terms of morbid physiology symptoms and signs hitherto inadequately explained. The temptation which we have to avoid is the temptation —however much and rightly we employ them— to rely too much for our opinion on laboratory tests and specialist information.

I wish to discuss with you to-day certain indirect clinical signs and symptoms which accompany disease of the hollow abdominal viscera, and to bring home to you the importance of endeavouring always in your work to search for a suitable anatomical and physiological interpretation for each symptom and sign which you record. Notwithstanding that in the pre-clinical period of our training we are encouraged to analyse closely each one of those normal phenomena which conspire to supply the evidences of symptomless health, there is, I think, a tendency in all of us to observe *without* explaining the clinical phenomena of disease; a tendency to group certain signs and symptoms together as suggestive of this or that diagnosis without sufficiently examining each of them individually. It is not, for purposes of our argument, enough to say that pain in the epigastrium is a symptom of gastric ulcer. We must go further and find out what kind of pain in the epigastrium, influenced for good or bad by what factors, and associated with what other subjective or objective manifestations, is to be regarded as a symptom of gastric ulcer. But, more important still, especially from the therapeutic point of view, we must aim at understanding how the pain which accompanies gastric ulcer is itself produced. To have an understanding of these things is as essential for us as clinicians as it is for the physiologist to have an understanding of normal gastric function and sensibility.

Actually, of course, our problems are extremely closely allied, for we are but concerned with exaggerated or disturbed reflexes, where the physiologist is concerned with normal reflexes.

The subject of visceral pain is too big and important for me to embark upon now, and I would only say in passing that there are two main schools of thought in regard to it. The first maintains that the viscera are themselves sensitive to appropriate stimuli, such as changes in intravisceral tension or tonus variations affecting their muscular coats, and that not only normal sensations such as hunger,

but also the disagreeable sensations of disease are dependent upon such factors. The second, following Sir James Mackenzie, denies the existence of true visceral pain and states that all so-called visceral pains are really felt in the somatic tissues supplied from the same segment of the cord as that from which the affected organ is itself supplied. Both schools recognise the existence of pain referred to the surface, but the first claims that it is a thing apart from true visceral pain. Personally I find the balance of evidence strongly in favour of the first school and those of us who have had the good fortune to experience visceral pain usually have had little hesitation in locating the painful sensations to a situation deep to the body wall, although sometimes perfectly aware of simultaneous referred sensations. It is with these referred sensations and other reflex accompaniments of visceral disease that I am to-day concerned.

We owe to Hilton of this hospital a debt of gratitude for some of the earliest observations on referred phenomena in disease, not only of the joints, but also of the thoracic and abdominal viscera and their containing cavities. His physiological explanations of pain and other protective mechanisms, such as muscular spasm, are full of enduring lessons, and are equalled only by his clear emphasis of the importance of physiological rest in the treatment of disease. Those of you who have read his lectures on Rest and Pain, delivered 60 years ago, will remember that, in the course of his dissertation on joint conditions, he correlates anatomical knowledge with clinical observation and shows how for better function in health and protection in disease a joint is supplied from the same nerves which supply the muscles activating it, and the skin covering it. Later he proceeds to introduce the abdominal cavity as a wholly analogous proposition and seeks to explain in a similar way the physiological interdependence of the abdominal muscles and the intraperitoneal organs. He points out how the recti abdominis, physiologically so useful in helping to support and evacuate the colon, when the colon is diseased and its walls inflamed become hard and rigid and immobile. In brief, he demonstrates in terms of morbid physiology the principles underlying the whole subject of the referred phenomena.

Sir James Mackenzie, in more recent years, has further emphasised the importance of the physiological interpretation of symptoms and has devoted special study to the elucidation of the reflex symptoms accompanying angina pectoris and other visceral maladies. To him we owe the terms "viscero-sensory" and "viscero-motor" reflex, employed to indicate on the one hand the painful changes occurring at a distance from the viscus, such as arm-pain in angina pectoris and shoulder pain in gall-stones, and on the other hand the muscular phenomena such as increased tonus or rigidity over an inflamed appendix or a gastric ulcer. One might also speak of a "viscero-secretory" reflex to describe the excessive or deficient secretion of the salivary and gastric glands in painful abdominal affections, or of a "viscero-visceromotor" reflex to describe the vomiting and painful gastric or pyloric spasm which may result reflexly from disease at some lower point in the alimentary tract. Finally, in conditions of very acute and severe abdominal pain, such as gall-stone or renal colic, we recognise that there may be a general overflow of stimuli resulting in vomiting, sweating, pallor, and in fact a collection of symptoms not unlike those found in surgical shock, yet all attributable to the reflex influences of a single painful visceral lesion.

I shall attempt to describe to you the more important of the reflex signs and symptoms encountered in certain well-recognised diseases giving rise to abdominal pain. From among these I have selected gastric and duodenal ulcer, gall-bladder disease, appendicular disease and renal calculus.

I shall employ the term reflex "symptom" to express a disturbed sensation of which the patient is himself able to give an account. By reflex "sign" I shall indicate a purely objective manifestation, or one requiring the co-operation of the patient and the observer. Thus I should call shoulder-pain or testicular-pain in gall-stone or renal-stone reflex "symptoms." I should call increased tonus or rigidity in a rectus muscle overlying an inflamed appendix a purely objective reflex "sign." I should consider the hyperalgesia of the skin overlying a gastric or duodenal ulcer a reflex "sign," but one requiring co-operation of patient and observer, although sometimes an intelligent patient may himself vividly describe the surface soreness which is left after an attack of pain.

It will perhaps be well to suggest here a routine for investigating and recording the re-

flex abdominal signs. I need not include mention of the ordinary methods of inspection and palpation for in these you are well versed and they are fully described in the text-books. For myself, I divide the abdomen into two upper and two lower quadrants and in each of these I start by testing the abdominal reflex, noting its general characters and particularly noting exaggeration in any one quadrant for reasons which will be apparent later. At the same time an eye should be kept on the patient's face where flinching or a slight contraction around the eyes may betray the presence of what I shall hereafter refer to as "superficial cutaneous hyperalgesia" or for brevity "superficial soreness." I next pluck up in each quadrant in turn between the finger and thumb the skin and subcutaneous fatty tissues with just sufficient force to prevent the skin from slipping as I draw it away from the underlying fascia, again noting the patient's face and only if he has shown no sign do I ask him if he has detected any difference on the two sides or in any one quadrant as compared with any other. Tenderness elicited in this way may be called "deep cutaneous hyperalgesia" or "deep soreness." Midline tenderness in the course of the linea alba above the umbilicus should first be tested by picking up the skin and working along a line from the umbilicus to the ensiform and then by gentle downward pressure with one finger along the same line. In this way "soreness" of the skin and "tenderness" of the deeper, but more sensitive extraperitoneal tissues may be differentiated.

I next palpate, but very gently, the upper and lower segments of the recti in each quadrant to determine the presence or absence of rigidity or of an increase in tonus which can scarcely be said to amount to rigidity, always comparing one side with the other, such rigidity I shall refer to as "guarding." Finally, I resort to deeper palpation and watch the patient's face for signs of pain, before proceeding to the routine examination of the abdomen by the usual methods.

In cases of suspected or possible gall-bladder disease I examine also for tenderness over the dorsal vertebræ; for pain induced by pressure immediately above the umbilicus; and for pain elicited by firm pressure on the eleventh rib on the right side behind.

In cases of possible renal or peri-renal disease I examine for the presence of increased tonus in the quadratus muscle group. Auscultatory and other examinations for impaired movement of the diaphragm in suspected inflammatory disease of the gall-bladder or kidney may also be included in the list, for increased tonicity of the diaphragm is sometimes a very valuable reflex sign.

To recapitulate, the abdominal reflex signs sought for are superficial and deep cutaneous hyperalgesia or soreness, unilateral exaggeration of the abdominal reflex, increased tonus or guarding of the rectus, especially when it is unilateral, and deep tenderness, which I think it is well to realise does not necessarily mean a tender viscus. To these may be added in a more detailed examination the other signs to which I have referred.

We can now proceed to discussion of the signs and symptoms common in cases of gastric and duodenal ulceration.

Of the symptoms, other than the direct visceral symptom of epigastric pain, the most prominent are vomiting, pain referred to the back or left scapular angle, and epigastric soreness. Vomiting, which is not particularly common, may of course in old-standing cases indicate organic narrowing in the body of the stomach or at the pylorus, but in the majority of the early cases in which it occurs is probably associated with spasm at one or other of these situations. Persistent pain in the back suggests involvement of liver or pancreas. Other occasional reflex symptoms include heart-burn, which is more common in other forms of dyspepsia than in ulcer dyspepsia, and which depends on reflex spasm of the cardia or lower œsophagus; and salivation, which is more common in duodenal than gastric ulcer, sometimes occurring in quite sudden gushes and accompanied by pain in the region of the parotids.

Of the reflex signs encountered in peptic ulcer the following are the most important and are met with in the order of frequency given. Deep tenderness, midline or unilateral or both; guarding, usually more marked on one side; deep soreness; unilateral exaggeration of the abdominal reflex; and superficial soreness. Any or all or none of these signs may be present. The commonest of course is midline deep tenderness, but unilateral guarding and deep soreness both occur, according to my notes, in from 30 to 40 per cent of cases. You may well ask why these signs are not more frequently demonstrated. I think it is partly

because they are not looked for, but a further reason is that *they are least conspicuous when the patient is suffering no spontaneous pain*, and the majority of patients with a chronic condition such as ulcer come to us in the intervals of pain or, having been put to bed in hospital, quickly lose their pain. If they are examined when pain is present or shortly after the pain has left them the signs are much more commonly found. In quite a considerable proportion of cases under my care in the wards during the past year I have been able to demonstrate their presence; in a few the signs have persisted for many days or even a week or two after the spontaneous visceral pain had been relieved. I have not found them present in healed ulcer cases such as an old standing pyloric stenosis; in those cases which have healed under treatment they have completely disappeared; and I have yet to find them in a case of functional dyspepsia—by which I mean a case in which no evidence of an organic visceral lesion is forthcoming. Their degree and persistence bear a definite relation to the depth of stomach wall involved and it is certainly my impression that they are most constantly present in those cases in which a definite ulcer-crater is shown radiographically. In nearly all the cases in which the signs have been right-sided, the ulcer has been duodenal or close to the pylorus. In the definitely left-sided cases the ulcer has been on the lesser curvature in each instance.

The following cases will illustrate my points.

J. D., male, aged about 50, was diagnosed clinically and with the aid of X-rays, test-meal and the presence of occult blood in the stools as having a duodenal ulcer. On admission to the ward he had deep soreness, deep tenderness over the right upper rectus, and the abdominal reflex was exaggerated in the right upper quadrant. The deep soreness was very marked and at times superficial soreness was also present, the patient volunteering the statement that the weight of a book as he read in bed and even of the bed-clothes was sometimes insupportable. The signs persisted for some time after he lost his pain, but then gradually became less and less distinct. Deep tenderness was the last sign to disappear, and its complete disappearance coincided with the return of negative occult blood reports from the clinical laboratory.

P. D., male, aged about 40, was diagnosed clinically and confirmed by X-rays, which showed a definite crater, as a lesser curvature ulcer. Superficial and deep soreness, deep tenderness, muscular rigidity and unilateral exaggeration of the abdominal reflex—all in the left upper quadrant, were recorded. On his discharge from hospital after several negative reports on the stools none of these signs were present.

A young man, aged 27, was diagnosed lesser curvature ulcer at out-patients and the X-ray report confirmed stating that there was a penetrating ulcer of the lesser curvature. On his first attendance he was free from pain and the only sign demonstrable was deep mid-line tenderness in the epigastrium. On his next visit he was actually in pain and he showed, in addition to deep mid-line tenderness, deep soreness in the mid-line, left sided exaggeration of the abdominal reflex, and left-sided guarding.

I was called to see a young man who had been under treatment for duodenal ulcer. During the past few days he had been free from pain, but had slight melæna. His private medical attendant, Dr. A. H. Harkness, demonstrated to me a most extreme exaggeration of the abdominal reflex on the right side. This was the only sign present, even deep tenderness being absent. The diagnosis was confirmed at operation a week later.

A man, aged 52, gave a history of hæmatemesis, of pain coming on two to three hours after food, of night pain and relief by food—a history strongly suggestive of duodenal ulcer. However, he had mid-line and left-sided deep tenderness and exaggeration of the abdominal reflex in the left upper quadrant. X-ray showed an ulcer projection on the lesser curvature. In view of his age and the presence of complete achlorhydria it was thought advisable to operate. A partial gastrectomy was performed. The ulcer proved to be non-malignant. More than once I have found the signs more accurate than the history in deciding as between a gastric and a duodenal ulcer. I have formed no opinion as to the value of these signs in gastric carcinoma; generally I have failed to demonstrate their presence.

In another case of duodenal ulcer, in addition to deep soreness, deep tenderness and muscular guarding, all confined to the right upper quadrant there was over the same area a beautiful localised exaggeration of the pilomotor reflex, and I was able to show repeatedly to my class a local patch of goose-

skin induced by simply stroking the skin in this region. This is the only case in which I have noticed this sign, though localised gooseskin in the areas of referred pain has been described after anginal attacks.

In interpreting the results of test-meals in ulcer cases and other dyspepsias, I think we do not sufficiently appreciate that here, too, we are concerned with reflex, but local reflex signs. For instance, the typical climbing hypersecretory curve which is obtained in a large proportion of duodenal ulcer cases and the closely similar curves which are met with in some cases of gall-stone or appendix dyspepsia merely express a reflex pyloric hypertonus which is preventing the normal neutralisation by duodenal reflex, though a positive gastric hypersecretion may also be present. In radiography, too, we rely largely on such local reflex signs as the opposing spasm.

The cases to which I have referred illustrate certain points which call for further enquiry. I would instance the persistence of referred signs after the original symptom has departed. Just as soreness of the skin and muscular guarding may persist in peptic ulcer, although no pain is being experienced, so we find in gall-bladder disease and renal colic that shoulder and testicular pain may be present without any other symptoms and even that they may come and go at times when there has been no visceral pain at all. It is difficult to explain this on any other theory than that which is commonly given of an area in the cord remaining irritated by stimuli received from a disease-focus. With regard to the inequalities in the abdominal reflexes, I think the explanation is fairly simple. The brisker reflex is obtained over the muscle which is in the most favourable state of tonus, that is to say the muscle which is "on guard," just as a brisker response is elicited on tapping the patellar tendon when the leg has been adjusted so as to secure an optimum degree of stretch for the attached muscles. The tonus depends partly on the general health of the patient, partly on local physiological or defensive requirements and partly on the local health of the muscle. In flabby individuals and women who have had many pregnancies it is quite common to obtain no response at all. A further reinforcing factor may be present on the receptor side and depend on the hypersensitiveness of the over-lying skin.

The reflex symptoms of gall-bladder disease (and here we must include gall-bladder infections as well as cholelithiasis) include pain referred to the shoulder, to the right scapular angle or to a point between the shoulder-blades. Not infrequently, too, the pain is referred lower down into the appendix region and many appendices have been removed for what were really gall-bladder symptoms. Apart from the true gall-bladder pain, which may be felt high in the epigastrium or under the right costal margin, we have to recognise a reflex gastric pain due to gastric or pyloric spasm, nausea and other genuinely gastric discomforts. I think there may also be a gall-bladder-colon reflex as diarrhœa or diarrhœa sensations are commonly present in cases of gall-bladder dyspepsia. It is just these symptoms referred to the stomach or bowel which make the gall-bladder dyspepsias, as opposed to the cases with unmistakeable colic or jaundice, so hard to diagnose. A further difficulty arises out of the close simulation of duodenal ulcer symptoms which is not uncommon in cholelithiasis, for in addition to right-sided pain, rigidity and tenderness, we may have hunger-pain, night-pain and relief by food. I believe that hunger-pain, night-pain and relief by food should be regarded as a pylorospasm syndrome and not a duodenal ulcer syndrome, its frequency in the latter condition being dependent merely on the fact that duodenal ulcer causes pylorospasm far more frequently and constantly than any other condition. Nausea, which is an important diagnostic symptom in gall-stone dyspepsia, and vomiting both presumably depend on gall-bladder-stomach reflexes.

The reflex signs include tenderness over one or more of the middle dorsal spines, more frequently in my experience over the third, fourth and fifth, than over the seventh and eighth, as the books describe; tenderness produced by firm pressure on the eleventh rib on the right side behind; tenderness in the abdominal wall immediately above the umbilicus at a lower level than the usual site of tenderness in gastric ulcer; an impaired entry at the right base behind; and guarding of the right upper rectus. I have come to regard impaired entry and rectus guarding, especially when they persist, as suggestive of a definitely infected gall-bladder. In other words just as the more pronounced and persistent signs in peptic ulcer seem to me to be found in those

cases showing a definite ulcer in the X-ray pictures and probably therefore to depend on a deeper involvement of the muscular wall and possibly of the peritoneal coat of the stomach, so in gall-bladder disease very definite and persistent signs probably indicate a greater degree of local inflammation. It is of course well recognised that rigidity is most constant in those cases which show such obvious signs of inflammation, as fever or friction sounds over the gall-bladder.

Any or all or none of the signs I have described may be present, and once more the time at which the patient is examined in relation to an attack is of importance.

A medical man was admitted to hospital for complete investigation on account of several attacks of severe epigastric pain which were quite undiagnosed. At the time of the investigation he was free from all symptoms. A week of thorough investigations by the various modern methods failed to clear up the diagnosis. The only positive sign was slight tenderness over the fifth and sixth dorsal spines. A few weeks later I saw him in an attack with a palpable gall-bladder and, on the following day, a rigid right upper rectus and friction sounds over the gall-bladder region.

At operation he was found to have a chronically thickened and inflamed gall-bladder full of stones. Some years previously he had been treated for dyspeptic symptoms associated with a dilated stomach, radiographically demonstrated, which was, I think, in all probability due to a reflex pyloric hypertonus, for the stones must have been there for many years, and there was no evidence of any primary gastric disease.

Mr. Ogilvie has kindly prepared for me some coloured diagrams, which I will pass round, illustrating the probable reflex paths concerned in the production of three of the referred phenomena encountered in gall-bladder disease.

You will notice that on anatomical grounds only one of these is quite strictly speaking a visceral reflex, namely, the scapular pain, in which the stimulus appears to pass via the hepatic plexus, the great splanchnic and sympathetic cord to the seventh and eighth dorsal segments, and therefore to a band which includes the neighbourhood of the lower angle of the scapula. The muscular guarding of the right upper rectus is probably a direct parietal reflex associated with an inflamed gall-bladder in contiguity with the peritoneum. The shoulder pain is similar in that it represents reference of pain from the diaphragmatic peritoneum via the phrenic to the fourth cervical area. Nevertheless, I think it is fair to include these among the visceral reflexes as they are so intimately dependent on disease in a viscus.

You are all familiar with the reflex signs and symptoms of acute appendicitis, which include vomiting, guarding of the right rectus, cutaneous hyperalgesia, spasm of the ileo-cæcal valve with cessation of cæcal gurgling on auscultation and secondary small-bowel distension, irritation of the psoas producing flexion of the hip and so on. The signs are so classical that we need scarcely concern ourselves with them here, though I trust you are equally familiar with the fact that the classical signs are not by any means always present. The question of the chronic appendix is a much more difficult one. It is a condition that is very frequently, but often very wrongly diagnosed, and the number of normal appendices removed annually must by now be very large. Pain and tenderness in the right iliac fossa do not necessarily mean appendicitis. Constipation, nervous apprehension of appendicitis in a half-educated public, too solicitous and deep palpation on the part of conscientious medical men, and pyelitis are common causes of these symptoms. An actually inflamed "chronic appendix" is, in fact, a rare condition, though even thickened and pus-containing organs may be present for long periods and give rise to dyspepsia and colic attacks often with slight fever. Careful examination for reflex signs during or just after these attacks may be helpful in deciding the diagnosis.

There is, however, another type of chronic appendix in which operation may become essential, although there is no persisting appendicitis, and that is the appendix which has produced or is the victim of some local mechanical interference, either by becoming adherent to the bowel, or by acting as a partial band or by being itself kinked or partially occluded. The symptoms in these cases are often entirely gastric and the pain may be all epigastric. Occasionally it may be demonstrated radiographically that at the time of the gastric pain there is an actual reflex gastrospasm. In such cases local pressure in the appendix region may cause epigastric pain or discomfort. As the appendix has no vagal supply, it is probable that we are here dealing

with an ileo-gastric rather than an appendiculo-gastric reflex. The diagnosis of such cases may be materially helped by employing Bastedo's inflation test, which is performed as follows. A rectal tube is passed a few inches within the anus and air is blown into the bowel with a rubber inflating bulb, the patient being asked at the same time to describe his sensations. Normally a sense of distension and a desire to pass wind is produced as the colon is seen and felt to distend. In cases of the type which I have described the patient suddenly places his hand over the appendix region and complains of pain, while tenderness may be produced or increased in this region.

The following two cases illustrate well the reflex gastric symptoms which may accompany this variety of chronic appendicular disease and incidentally the value of Bastedo's test.

Mrs. D. was admitted under my care into Esther Ward in 1920 for epigastric pain and vomiting. On one occasion she had brought up a little blood. The investigations gave no material help, and I finally made a diagnosis of gastric ulcer and treated her accordingly. With rest in hospital she improved, but soon after returning home the symptoms came back and she also began to complain of hypogastric mid-line pain. She was re-admitted this year for troublesome epigastric and hypogastric pain and vomiting. While observing her under X-rays Dr. Campbell had the good fortune to see the stomach during an attack of pain. It was undergoing excessive and abnormal contractions; the pain was all epigastric. On returning to the ward she vomited some barium which was streaked with blood. Next day while tracing the opaque meal in its further stages, Dr. Campbell reported that the transverse colon in its second half appeared to be in a state of spasm and tender; the patient was at this time experiencing her hypogastric pain. It appeared, therefore, that she was suffering from reflex spasms of her stomach and colon and that these were responsible for her two pains.

On re-examining her I thought she seemed tender in the appendix region and performed an inflation test. Immediately she cried out and placed her hand over the right iliac region. Mr. Turner operated and found a definitely kinked appendix with a band constricting its middle portion. Stomach, duodenum and gall-bladder were all free from disease. The appendix was removed and for three months the patient had no further symptoms.

To my great disappointment she has now returned and complains again of the same two pains (but no vomiting). I am confronted with the problem of deciding whether I was quite wrong before, in which case her three months' respite was a coincidence, or whether there is still a mechanical fault in the ileo-cæcal region.

Mr. N., aged 38, came to see me on account of epigastric pain and vomiting. On purely clinical grounds I regarded him as probably suffering from a juxta-pyloric ulcer and even thought he might have a commencing pyloric stenosis. The attacks had become more and more frequent and he had lost a good deal of weight. At a later examination there was tenderness at McBurney's point; an inflation test was positive. At operation, six months ago, Mr. Turner found a kinked and adherent appendix which appeared to be controlling the ileo-cæcal opening. Stomach, duodenum and gall-bladder were healthy. The appendix was removed and there have been no further gastro-intestinal symptoms. Here then were two cases (the second more satisfactory than the first) of epigastric pain, seemingly associated with appendix trouble, in both of which there was reason to suppose that the main symptoms were due to reflex gastro-spasm, or to a viscero-visceromotor reflex.

The reflex dyspepsias, whether secondary to gall-bladder, appendicular or other abdominal disease comprise an important group, and it is essential that we should collect information as to the way in which their symptoms are produced.

In discussing the referred phenomena attending the passage of a renal calculus I shall ask you to pardon me for utilising some observations made in my own case between February and July of this year. To me the whole episode, though at times very unpleasant, was of great interest, and I endeavoured to keep as careful and unbiassed notes as I could both of the visceral pain and of the referred signs and symptoms. I feel sure in my mind that the visceral pain was deeply situated and not a somatic phenomenon. On the first occasion on which I experienced renal acheing I did not recognise is as renal and thought it was colonic, even going so far as to pay several visits to the lavatory, with more or less ineffectual and slightly loose results. On many occasions thereafter I had the sensation of wanting to have the lower bowel relieved. I now believe that these sensations, though not

the loin-ache, were due to a kidney-colon reflex.

In the worse attacks I always noticed that as the pain increased my saliva dried up, appetite disappeared, and nausea commenced. When the pain became maximum there was retching, vomiting, pallor, sweating, grunting, and most definite rigidity of the quadratus lumborum on the affected side. This rigidity at times persisted after the attack was over, and sometimes the muscle was tender just in the way that a muscle becomes tender after unwonted overuse. The stone very soon passed into the lower end of the left ureter, where it remained for four months. During this time darting pains in the left testicle and pains in the left side of the penis were often noted, but were not at all necessarily associated with the attacks of colic. I did not notice drawing up of the testicle, due to reflex contraction of the cremaster, nor the testicular tenderness which have been described. A very definite induced symptom, which was, I think, a direct visceral symptom, was loin-pain or discomfort on gently thumping the lower ribs from behind on the affected side. This was present for several days after an attack, and was present, moreover, in complete absence of any tenderness on ordinary deep palpation. The same symptom was induced by running down-stairs or other forms of jolting.

I consider, therefore, that, in addition to visceral pain, I experienced a viscero-sensory reflex in the testicular pain; a viscero-motor reflex in the rigidity of the quadratus; a viscero-secretory reflex in the inhibition of the salivary secretion; and viscero-visceromotor reflexes in the nausea, vomiting and diarrhœa sensations; while finally in severe attacks there were present numerous "overflow" phenomena such as sweating, grunting, vomiting and pallor.

The reversibility of visceral reflexes is a side issue of some interest. I have been struck by the extraordinary similarity between the loin pain which follows a blow on the testicle and the loin pain of renal calculus in the acheing stage. I imagine that the former probably represents a testicle-kidney reflex or the reverse image of the kidney—or ureter-testicle reflex in renal colic.

I have also notes of a case of severe dyspepsia, with epigastric pain and X-ray findings suggestive of pylorospasm, due to a small linea alba hernia of the extraperitoneal fatty tissue. At operation no disease of stomach, duodenum, gall-bladder or appendix was found, and recovery followed removal of the herniated tissues. It is just this layer which becomes sensitive in gastric ulcer, so it would seem that disease of the stomach wall may produce reflex hyperalgesia of the extraperitoneal fatty tissues, and disease of this tissue may produce painful contractions in the stomach wall.

As to the actual diagnostic value of reflex points of interest, there are wide divergencies of opinion. Some have so strongly urged their merits as to seem to suggest that abdominal diagnosis is at once made easy for those who will properly employ them. Others have pronounced them to be of insignificant value. I feel sure that the truth lies somewhere between these extremes, and that the signs, if carefully observed and assessed, enhance the accuracy of one's diagnosis.

It would not be fair to you to leave this subject without some reference to certain fallacies which you should bear in mind when examining your patients. In the first place you must be very careful not to put any leading questions such as "Does this hurt you here?" while examining for hypersensitiveness. In the second place you must appreciate that in neurotic individuals, and especially in the post-operative neurasthenic, little or no reliance can be placed on the reflex signs. Here, as always in medicine, an estimation of the general physical and mental "make-up" of the case is essential before the utility of symptoms and indirect signs can be assessed, and the psychological effects of long-continued pain or ill-health must always be taken into account.

Universal hyperæsthesia and rigidity are commonly present in these unfortunates, though the rigidity is usually of that intermittent type which can be readily differentiated from the true reflex hypertonus of peritoneal or visceral inflammation.

Lastly, I do not want you for one moment to go away with the idea that the physical examination and the search for physical signs is the most important part of your clinical investigation of a case. Generally speaking a good history and record of symptoms must have the first place. Then follows a careful clinical examination of the patient, including a survey of the reflex signs, and only when this is complete and your opinion as clearly as possible established should you feel justified in ap-

pealing for the often invaluable help of the radiologist and the chemist.

Although it may seem a counsel of perfection, I should like to impress on you once more the importance of trying to see your patients at a time when they are actually experiencing their symptom, or even sometimes of taking steps to produce their symptom. Thus a gastric pain may be induced by a full meal or by starvation; a gall-bladder symptom by jolting or exertion; an appendicular pain by the inflation test. Personally, in a case of obscure abdominal pains, I would rather see the patient in the course of an attack with nothing to help me but my eyes and hands than have him under observation in the most up-to-date hospital for a whole month in an interval between attacks.

Try to observe symptoms accurately and to interpret them physiologically. By so doing you will improve both your diagnosis and your therapeutics, for in Hilton's words, "every pain has its distinct and pregnant signification, if we will but carefully search for it."

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Reform of Medical Education.

SIR,—There seems to be a slack time in September, when the Editor of the GAZETTE runs short of topical matter, and the Editorial mind applies that easy discursiveness which it acquired among the light oddments of the brisker months to some more ponderous subject. At a fatal moment you were tempted to discuss the reform of medical education. You began by endorsing the safer platitudes about the irrefutability of the plea for a good general education, and piously repeated the stock prize-day phrases about the doctor as a man of breadth and wide outlook. The only light on the meaning you personally attach to these phrases is that shed by your later remarks. From them one gathers that these great possessions which they indicate are to be acquired during a school course in the primary sciences, bowdlerized under medical direction, and taught by schoolmasters who must on no account be "scientific teachers," lest they overstep the limits fixed by a medicated syllabus. In this way the danger of laying undue stress on details of science not considered relevant to medicine is to be avoided.

In fact, the intolerable burden of providing the doctor's mental breadth and vision is to be lifted off the hospital years and cast upon the scholastic period. You and those others who advocate this policy seem not to be aware of the fact that the school years are already overburdened to the extent of being a national calamity, and that boys commencing their special studies for the learned professions are commonly unable to think clearly or to write connectedly in grammatical English.

You and the reformers you support occupy a ridiculous position pendulous between two policies namely, the old "wide outlook" policy and the retrogressive one of converting the hospital period into an apprenticeship in the practice of medicine and surgery. The former is really no more than the dead letter of a verbal piety; the latter is the working principle.

Modern medicine is stated to have grown to such proportions that an extra clinical year is needed in order to tackle it, and the fundamental sciences must be sacrificed. Has it ever struck you that the less training in science the medical profession receives the faster its literature will grow by mere accumulation of details of medicine not relevant to science? In fact, a survey of current medical literature shows that the vicious cycle is already started. You, sir, will have long been pained by these œdematous growths, since a mere biological principle like a floral diagram still looms huge in your memory. When, however, you complained of the Law of Periodicity, I stood aghast before the revelation of an intellect to which that great conception had failed to appeal. If indeed these fundamental teachings of science are generally considered as inflictions by the new medical student in his violent hurry to qualify, it is sadly true that the preliminary studies are a waste of his time. The relevant facts of science might probably, as in other branches of the curriculum, be put in synoptic form by a "medical teacher," with suitable mnemonics and doggerels to render them more impressive. Such a system would relieve the schools and at the same time give the medical profession of the future the kind of education which you seem to think it needs. Its establishment would undoubtedly be hastened by giving not only the newly qualified, but also the newly registered a preponderant vote on the General Medical Council, and the Editor of the GAZETTE in the new age would cant no more of breadth of mind and width of outlook,—Yours,

E.

Guy's Swimming Club.

DEAR SIR,—Perhaps the members of Guy's Swimming Club may be interested to learn that Mr. E. T. Crosoers, who last year plunged 60ft. 9in. for them in the Inter-Hospital Swimming Sports, competed

in the A.S.A. Open Plunging Championship on the 14th inst. He reached 60ft. 8ins., and so becomes entitled to the Association's Standard Certificate for exceeding the 60ft. standard.

With best wishes to the Guy's Swimming Club,—Believe me, yours, etc.,

E. T. C.

DEAR MR. EDITOR,—As Ambroise Paré died in 1590, I find it difficult to credit him with surgery done "in the Napoleonic days." (GAZETTE, p. 384). Yours faithfully,

E. W. B.

Guy's Hospital.

Guy's Hospital Clubs' Union.

THE formation of the Clubs' Union, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the Hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Year Book) to the Clubs' Union, any student of the Hospital can obtain the privilege of membership of the constituent institutions.

The Union comprises the following Constituent Institutions:—Association Football Club, Athletic Club, Boat Club, Cricket Club, Debating Society, Dental Society, Gazette, Golf Society, Hockey Club, Lawn Tennis Club, Pavy Gymnasium, Physical Society, Rifle Association, Rugby Football Club, Students' Club, and Swimming Club.

On joining the Union a Student is entitled to take part in the activities of any of the above Constituent Institutions. The ground of the Clubs' Union is under the control of the Council, is situated close to Honor Oak Park Station on the London, Brighton and South Coast Railway, and to Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. A Fives Court, under the management of the Students' Club, is situated behind the Nurses' Home near the Swimming Bath, and arrangements are made for classes in boxing, fencing and gymnastics in the Pavy Gymnasium. The Boat Club is affiliated to the London Rowing Club at Putney, and members are entitled to all the advantages of that Club. Meetings of the Debating, Dental, and Physical Societies are held from time to time in the College.

The membership subscription of the Union has recently been raised to five guineas. In spite of the large increase in the number of members, a rise in the subscription rate (perhaps only a temporary one) was necessitated by the rise in the cost of labour and material.

Extensive alterations have been carried out in the Students' Club to provide greater accommodation and comfort for the members, and are dealt with in a separate paragraph on the Students' Club.

At Honor Oak Park a new Stand has been erected to seat 800 people, so that now with the two existing small stands there is seating accommodation for 1,000 people. It is hoped that improvements to the Pavilion will be commenced shortly.

As any student can see, these alterations in themselves necessitate an increase in the membership subscription. The Utopian ideal of a new Students' Club may even yet be realised in the future, thus adding another burden to the finances of the Union.

Membership cards have been issued entitling the holders to the privileges of membership of each of the Constituent Institutions.

New members should consult the notice boards in the Colonnade for information as to the activities of the various Clubs.

An excellent programme of home matches has been arranged by the Rugby Football Club (*vide* Fixture Cards), and it should be noted that free admission to the ground during matches at Honor Oak Park is granted only to members of the Union on production of their membership cards.

STUDENTS' CLUB.

The premises of the Club include the Smoking and Reading Rooms and the Dining Hall, in the College.

All three rooms have recently been redecorated, and, in addition, alterations have been carried out in the Dining Hall and the Smoking Room. It is hoped in this way not only to increase the accommodation, but also to expedite the service during meal times.

In the Reading Room the periodical cases have been renovated and the paper stands have been brought up from the Smoking Room, where they used to be in a state of decay.

A good supply of papers and periodicals is now maintained, and it is hoped that all members of the Club will assist the Committee by themselves seeing that the periodicals, etc., are kept in good order. The taking of periodicals out of these cases or the removal of papers from the Reading Room throws a lot of extra work on to the Librarian, and members ought not to expect the Committee to keep up a constant supply of papers if these are continually removed as soon as they are placed in the Reading Room.

The Library in the Reading Room has also been thoroughly re-arranged. A new catalogue has been made, and can be inspected at any time.

Notices are posted in the Reading Room stating the regulations of the Library, and students should avail themselves of this opportunity of a good supply of general literature which for once has no connection whatever with medicine.

Through the Library, books may also be obtained from Mudie's Library.

At a meeting of the Clubs' Union Council on September 26th, 1921, the following officers were elected:

President.—Dr. Lauriston Shaw.

Chairman.—R. P. Rowlands, M.S.

Committee.—F. J. Steward, M.S.; J. A. Ryle, M.D.; T. B. Johnston, M.B., B.Ch.; W. K. Fry, M.C., L.D.S.; P. O'Meara, A. H. Douthwaite, K. Hooper, R. Jarman.

Treasurer.—G. H. Hunt, M.D.

Hon. Secretary.—W. D. Doherty.

Asst. Secretary.—C. H. Toussaint.

Auditors.—Messrs. Toussaint and O'Meara.

There will be a new election on October 10th.

The attention of all members is drawn to Rule 20 of the Clubs' Union:—

"Every member whose subscription is more than one month in arrear shall be suspended from the privileges of membership, and his name shall be posted in the Students' Club. After two months' default he shall cease to be a member of the Union, and shall not be re-admitted without the consent of the Council, who shall, if they think fit, impose a fine of five shillings upon his re-admission."

A list will shortly be posted in the Students' Club of members who have failed to comply with the rules, and the Secretaries of Constituent Institutions will be notified that the members named are not entitled to the privileges of the Union until their subscriptions have been paid.

W. D. DOHERTY,
Hon. Sec., Clubs' Union.

Specialities.

Messrs. HARPER, SONS & BEAN, LTD., Wadden Pool Works, Dudley, Worcs.

The 11·9 *"BEAN" Sedan Car.*

The "Bean" Sedan is a most useful little Car, handsome in design and finish, which can be run at a cost of less than 2d. per mile.

Some very severe tests have been made with this Car, and it has proved itself equal to the very best makes obtainable.

The price is very moderate, and the makers give a six months' guarantee to every purchaser.

Reviews.

Notes on Gynæcological Nursing. By Félicie Norton. (Scientific Press, Ltd.) First Edition. Price 1s. 3d.

This is a helpful little book, especially to nurses in training, as it is clear and concise and only deals with gynæcology from a practical nursing standpoint. It supplies necessary information without unnecessary details.

Aids to Organotherapy. By Ivo Geikie Cobb, M.D., M.R.C.S. (Messrs. Baillière, Tindall & Cox.) Price 6s. net.

We recommend this small book of one hundred and eighty pages to anyone anxious to learn the scope and principles of organotherapy in a few hours. The author has given a concise summary of our present knowledge of this subject, and, although unable to give details of either clinical or experimental in so short a work, has appended a useful bibliography. The book will also be found useful by students of physiology, the interdependance of the endocrine organs being clearly explained. The last chapter, including sections on "Pluriglandular Products" and "Hypo-endocrinism," contains many interesting theories and a few cases are cited, in which organic preparations have effected cures, after failure of the more generally recognised therapeutic methods.

Practical Plant Biology. By Professor H. H. Dixon, F.R.S. (Messrs. Longmans, Green and Co.) Price 6s.

It serves no useful purpose to comment on this little book in the GAZETTE. In the good old days when the medical student wasted valuable time doing things for the growth of his mind and the good of his soul, this book would have received its merited welcome. It is now widely used in benighted Ireland, but here in London, where our architects are giving the medical curriculum the precarious equilibration of a Heath Robinson chateau, such a book is too good to be useful, except to the student of science.

Botany for Students of Medicine and Pharmacy. By Professor Fritch and Dr. E. J. Salisbury. (Messrs. G. Bell and Sons.) Price 10s. 6d.

The authors of "An Introduction to the Study of Plants" have here re-written and adapted that excellent text-book to suit the requirements of 1st M.B. and Pharmaceutical students. The present work preserves the distinctive character of its original in that it shows the student how to do and see for himself with no more experimental outlay than is covered by an elementary Chemistry set. The medical student can complain that the double catering

has led to a rather scanty treatment of a few of his types, especially Pythium.

There is an introduction by Professor Boycott which, if thoroughly assimilated by but one generation of medical students, would be worth the price of the whole edition.

Voices from the Past.

(Continued.)

Resurrectionists.

It was in this same winter that an old surgeon, long retired, called on me and looked round the hospital. He was very interested in the contrast between the things as he then saw them and as he recalled them in his own student days. His home as a boy was in the extreme north of England, long before railways were invented and when travelling long distances in the winter was a serious undertaking. The University of Edinburgh drew its students from the entire northern area. No one there thought then of going to London.

There was great difficulty in getting bodies for dissection in those days. The public were in a very sour humour on the subject, and did not hesitate to demonstrate their anger openly regarding the methods by which, it was said, bodies were obtained for the dissecting room. Burke and Hare were known to resort to actual murder, and haunted lonely ways at night in order to secure victims. Graveyards were rifled of their bodies, and it became customary for friends and relatives of a deceased person to form night watches until the body had been buried long enough to become useless for dissection. It was during his student days that an infuriated mob attacked Surgeons' Hall in Edinburgh and tried to burn it down. He was inside at the time dissecting and, being young, enjoyed the excitement immensely.

The dissecting case he was using then I have now. In my student days it was my dissecting case also, and afterwards I used it for minor surgery. I have had many boxes of scalpels besides this, but none of them could displace the old dissecting case from its position as first favourite. The reasons seemed to me to be these. I was familiar with them and the touch of the handles and the shape of the blades. In fact, with one of these in my hand there was a total absence of strangeness, or of different grasp. I had cases of metal handles, solid handles, fenestrated handles, and blade handles forged out of one piece of steel, to say nothing of scalpels in cases for lithotomy, nasal and oral operations, cases for tracheotomy, etc., etc. Even sometimes in amputations I preferred them, but always where I had to face a tedious dissection, such as removing an extensive infiltration of glands and tissue in the neck, I always fell back on the old case. The big-bellied blades of so-called "operation" knives are not to be compared with the sharp-pointed isosceles-triangled blade of the dissecting room, when the jugular and other veins, the pneumo-gastric nerve and other parts, such as the chords of the brachial plexus, etc., have to be cleaned from a mass of adherent tissue. How many times those knives have been boiled and then lain for hours in their wet trays wrapped in wet lotion! Yet they kept their edge better, and wore better, than any other edged steel I possessed.

I have sometimes wondered why some surgeons can operate (for they say they can) as well with a strange knife and a rubber glove as they can with the delicate sense of touch in full play. Candidly, I cannot. Perhaps I am naturally too clumsy.

Braxton Hicks.

One of the Staff who held this view, long before I knew its value, was Dr. Braxton Hicks. The Charity had to assist him in his lectures on Operative Midwifery, and he always insisted on the operation being performed with either hand. "Supposing your right arm was injured," he would say, "and you had suddenly to perform a 'turning,' an arm, or a breech presentation, how would you fare if your left hand had never been taught?" So he made all students practise with the left hand. It will be seen, therefore, that our chief difficulty as assistant teachers, was teaching the left hands of students.

After hospital days, the effect of all this was that I much preferred to use my left hand for all this kind of work. Far from being ambidextrous, I preferred the right hand for all other operations. An experience of over fifty years has shown me the wisdom of Hicks' plan.

He was a short corpulent man, with little fat hands and short fingers. How he managed to explore the lower pelvis p.r. we never could understand, but he did. He very rarely expressed doubt, but laid down the law dogmatically. Very different was his successor, who was a polished gentleman, but politely deferential.

Hicks was a very rapid talker, and seemed to use only his lips, which he occasionally touched with the tip of his tongue. I was never tired of watching those busy lips, reminding me of the rapid click of a telegraph needle.

Millikin, the Instrument Maker, and his Successors.

I don't think the Gazette is old enough to remember old Mr. Millikin, instrument maker to Guy's; when I first knew the hospital in the sixties, his shop was on the north side of St. Thomas's Street, not far from the High Street. It was well situated for the "United Hospitals," before St. Thomas's was pulled down.

Then he was succeeded by his son, who carried on the business for some time, when it changed to Down Bros. who still keep the hospital patronage.

Monson Hills.

Then about the time the Gazette appeared, H. J. Hills, the brother of old "Mon," or Monson Hills, opened a shop in Newcomen Street and was patronised by some of the Guy's men on account of his relationship to "Mon."

I can never find a satisfactory reason why "Mon." should have been such a settled institution at Guy's. He had very few duties. He was practically an old pensioner who spent his time in strolling about the colonnade. He was a part of the place, and to be adopted as a Guy's man by "Mon." was to feel indeed a part of the institution. He always wore a smile which broadened considerably on recognising a friend. He had soubriquets for some and a hearty laugh for all. He never called a man by his Christian or surname, but generally as "P'fessor." There were just then many at Guy's from Nottingham, these were all "Young Noringhams" and a hearty laugh. He was never cross or in an ill-humour, and anger was out of the question.

You required no introduction to "Mon." It would have made him so solemn that he would have laughed at you. Photos of groups of the Residents were taken every half year, and it was essential that "Mon." should be in all. As a first or second year's man you would not probably see very much of "Mon." but in your later years it was your duty to see that he never went dry. The usual place, then, for a casual glass of beer was "The International," a bar in St. Thomas's Street dropped down from London Bridge Station. Thither "Mon." was often dragged, not only every day, but, if he would, often every day. I never saw him under the influence of drink, except, perhaps, when he looked occasionally a little sleepy. We sometimes wondered how much he really did take, or if it were possible to make him drunk. His so-called "care" of the instruments and splints was a sinecure, and his assistance in the theatre where he stood threading the needles and twisting the ligatures in his grimy fingers was a duty which might have been done by the students with advantage or even by Millikin who stood handy to hand the knife, or the saw, to the operator. What a relic of barbaric dignity that was, the attendance of the official instrument maker to hand the instrument. What an essential part of the pomp and pageantry of surgery, the shadow of the "Science and Art," until Lister came and displayed the "Principles" which make the grand reality, the foundation of our present Surgical Practice. Millikin might pass the instruments, but "Mon." would not give up the silk.

As his sight grew dim and he had to bite and moisten the little thread in his mouth, I used to think his head leaned more and more towards his shoulder and his knee valgus got more and more bent, and his face more puffy and sallow, but his smile was as broad, and his voice as hearty as ever when he hailed an acquaintance, at the end of my six years as it was when I first went up.

It is an impossible thing to represent the position "Mon." held among the students, by a written description. He was a nonentity, and yet he was the link that bound them to the past generation of students.

He was made much of, not because he filled an important post, or did important work, but because the students felt that he had been passed on to them, and committed to their charge by those who had gone before.

That was his real official position—to be a sort of social figurehead. That is the reason one so often heard at lunch time, "Come on, Mon." His capacity was limited, but he had no false modesty; on the other hand, he never forgot himself or presumed to take any advantage of the familiarity with which he was treated, or give himself any "airs."

He was like Mr. Stocker, a voice out of the past, but Stocker was quite aloof from the

students' social life; his was a business connection, but "Mon." was of them, and among them. His face and figure was the official stamp on the photos of the Residents; he was the foster mother of their being Guy's men. No description of the time would be complete without a thorough explanation of this genial figure with pince-nez and grey frock coat. Everyone who has seen the numerous photos of the period or whose friends or relations have spoken to them of these times, but must have wondered, "Who is this fat old man, and why is he always present in these groups? Was he the Dean, or the Superintendent?" No, he was only "Mon."

THE DRESSERS.

I am reminded that it would be interesting to know more details of the work which the dressers and House Surgeons had to do at Guy's fifty years ago. It is too long ago to speak on this point with much accuracy of detail. A good deal also depended on the dresser himself, and the Surgeon for whom he dressed. My admiration, nay more, my love and veneration for the surgeons and physicians of the time is too great to admit of the possibility of my saying anything which will seem to put any of them into a false position meriting disrespect, but naturally at times there is an appearance of shadow.

The surgeon for whom I dressed was Arthur Durham, the junior of the four senior surgeons. Another co-dresser was appointed at the same time as myself, the third being the one remaining from the last three.

I have nothing but praise to say of Durham. He was a model of geniality and kindness. He in no way neglected the least of his duties, but if his dressers showed their fitness, he saw that they reaped their reward. My duties, in general terms, were about as follows :—

To attend the large O.-P. room on Wednesday morning and pick out from the people there applying for admission all cases that I wished to have. If any of the others were, in the opinion of the H.S., such as ought to be admitted, he dealt with them afterwards.

The cases waiting here were chiefly chronic, patients who had been advised by their doctors to come at that time, also some from the O.-P.'s, breast tumours, bladder and rectum, as well as scrotal and cutaneous cases, enlargements, in fact all sorts, more or less, found their way at times thither. Then the dresser for the week was supposed to have the first call on those who were sent up from the Surgical O.-P.'s.

It was a privilege always conceded to the Dresser for the Week to select his own cases, as he was supposed to know the class of case his surgeon preferred to have in his beds. The H.S. had power, if he chose to exercise it, to have overridden the decision of the dresser, but it was never done. If the case had to come in, and the dresser did not want it, it was sent into another ward.

He took also all accidents and emergencies, strangulated hernias, acute intestinal obstructions and such like. He had to dress all wounds, set all simple fractures, and compound too, if no operative treatment was required. On the next point there was great variety, as I said, according to the man and the surgeon he dressed for. I was given to understand that in smashes of the hands and feet, I must myself take full charge up to the metacarpus and metarsus. Beyond this and up to the wrist the H.S. must be responsible. This was far from being the rule with all, but that was my position received from Durham.

As dresser one had to trim up numerous "finger" cases' and once when H.S. I was removing the three middle fingers and the heads of the metacarpus when Durham came into the ward on his rounds. He merely glanced at us and said, "When you have finished what you are doing, I wish you to come to me."

The dresser had entire charge of all operation cases and during the operation was the surgeon's chief assistant. I cannot speak of the number of beds he had. That depended on how they fell vacant and what "luck" he had. The vagaries of this same "luck" were proverbial. I knew one man who never had a strangulated hernia, others sometimes had many. Acute intestinal obstruction at times was entirely absent; at others there would be quite a run. There were three dressers to each of the four surgeons, they "took in" therefore twice in their six months of duty. There was plenty to do and his time was fully occupied. The dresser was nominally under the control of the H.S., but a good H.S. but rarely interfered with a good dresser. I will give such an instance and it will suffice as a type.

Durham had just concluded an operation of what was then called "perineal section." It was done for the drainage of a large suppurating area, probably originating in a ruptured urethra, following the low chronic inflammation

which always occurs with dilatation going on to bursting. The area involved was very extensive, and the man's condition was very low. He required no chloroform, as he was already unconscious. Pulse running and feeble, with cold clammy skin. As it was probable that he would not live until his next visit, Durham said to me, "I'll leave him entirely in your hands, but he will die."

Now here is a chance, thought I, of getting a little kudos. So I instructed the sister (he was up in Samaritan, being much too foul a case for a general ward) to feed him with stimulating slops, such as beef-tea and milk, telling her to give him regularly every hour one ounce of brandy. She did so, and altogether backed me up splendidly. Meanwhile I kept the wound as clean as I could and attended to the hygiene of the case, such as fresh air, warmth, etc. He did not die that night, but gradually regained consciousness. One thing he seemed to do well instinctively, and that was to swallow anything containing brandy. At last he was able to turn his head and look around him, but there was no suggestion of intoxication, although he took his 24oz. of brandy day by day. Presently it was knocked down to 18oz. At this juncture, a new H.S. came on duty. An excellent fellow, but a strict teetotaller. He approached me on this man's consumption of brandy. Did I think it really necessary? Well, was it not probably too much? In no way did he attempt to use the authority which was his own, if he cared to employ it. It was my duty, therefore, to meet this courtesy by equal politeness. I replied by stating his original condition and the words of Mr. Durham and how I thought that, except for the brandy, he would have died in twenty-four hours. He somewhat, therefore, relaxed his first rigidity and met me half-way. It was agreed that the 18oz. of brandy should be changed to the same amount of sherry and then afterwards according to progress. The man made a good recovery, and left the hospital pretty fit and with a sound urethra, a fact on which Mr. Durham did not fail to see that his dresser got his due share of praise.

I quote this to show the relationship of H.S. and dresser. In all stricture cases I had to do the daily dilatation, according to the directions of the surgeons. This to me was invaluable in after-life. All these duties, and keeping a close watch on all who wore splints and other apparatus, kept a dresser busy from morning till night. The numbers of beds under the care of each dresser varied. Each surgeon had two large wards. At the end of his week the majority of these beds would be filled by his cases, getting gradually less until it was his turn to take in again. The other dressers in their turn having the majority. But, as I said, much depended on the dresser himself. After our time was up, my colleague and myself often went round with Durham to follow up the progress of the cases in which we had taken such an interest. In one thing, I should add, we had always been very particular, and that was to see that the bandages and dressings on the patient were always clean and tidy when Durham came round. The more copious the pus, the greater the discharge, and the dirtier the case was, the greater was the attention bestowed on this point. Imagine our dismay on going round after our time was up, to see these worst cases reeking with sanious pus and stinking most offensively (credite, posteri homines areptici), bandages untidy and the whole thing in untidy disorder. I said once to my successor, "Aren't you going, Blank, to clean this case up before Durham comes this afternoon? Its bad now, but it will be poison by then." "I'm not," he replied, "I'm not going to be at the trouble of dressing cases twice a day." I said nothing, but noticed that the face of Durham was losing its genial smile of general approval as he went round. My old colleague and myself agreed that it was a brutal shame to spoil such a good man, but said nothing more, as we were powerless. One day, however, Durham took me on one side and said, "I've tried everything with these men; I tried scolding and I've tried kindness; I've tried reproof and gentle words; but it is all thrown away, it is useless. Now, I'm going to try the other thing." He did, and from being one of the most pleasant and generous surgeons that any dresser could ever wish to dress for, he turned into a regular demon and showed that the iron hand lay within the velvet glove. O, dressers! be careful of your work not only for yourselves, but for the sake of those who come after you.

(To be continued).

Guy's Hospital Dental School.

The Newland-Pedley Gold Medal for Operative Dentistry has been awarded to Mr. F. A. Nicolai.

The Fourth Year's Prize in Dental Subjects has been awarded to Mr. B. Rubinstein.

Rugby.

GUY'S v. CATFORD BRIDGE.

With this match at Bellingham, on September 16th, Guy's commenced their 79th Season, so I am reminded by Dr. R. M. H. Randell, of Beckenham, who was Captain of the Hospital in 1883. Still a keen supporter of his old Hospital there are few matches in London, in which Guy's are engaged, that Dr. Randell does not attend. Guy's were not strongly represented against Catford, though that should be no excuse for the rather poor show that the forwards put up. They were not together and appeared to lack leadership, lack of training was also evident, but this was to be expected so early in the season.

A strong cross wind interfered somewhat with accurate handling, and the forwards heeling slowly, there was little snap about the men behind them, consequently both wing men were frequently bored to the touch line before they could get far. Mostert made one or two good runs and Albertijn did his best to cut through; sometimes Steyn on the right got going, but so many passes were judged to be forward that not till some 25 minutes had elapsed did a score come; the result of a fine opening and good handling by Eprong, Steyn, and the new Captain, P. K. Albertijn, who had got across in time to take an inside pass and score the opening try of the season which Neser converted. One more score was registered before half-time; Van Schalkwijk getting over after much good work in which Du Toit was prominent. This try was not converted and ends were changed.

The second half was mainly in Catford's favour, their forwards certainly played a hard bustling game and the backs stopped our backs' progress on many occasions. Our line was not often in danger but territorially the home side had the best of it. Towards the close of the game Steyn was a try-getter, but he made the opening himself and the effort was both opportune and clever. Van Schalkwijk and Albertijn had previously cut out what looked like an opening, but a partial tackle of Albertijn led to the ball going behind Steyn who promptly ran back to pick up and then turned to run to the posts for Van Schalkwijk to goal. The final score was Guy's, 2 goals 1 try (13 points) to Catford's nil. Taylor and Harvey were the pick of the forwards; behind, Van Schalkwijk was in excellent form. Du Toit looks a likely newcomer.

Guy's Team.—W. Badenhorst, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, D. Mostert, E. L. Sprong, F. Bekker, W. H. Taylor, E. E. Neser, F. J. Biddle, P. G. Harvey, F. G. Hutchinson, N. M. Holloway, P. J. Du Toit, D. Vorster.

GUY'S v. COVENTRY.

The Guy's team that went to Coventry on September 23rd covered itself with glory. It differed a little from the team that did duty at Catford., B. C. Scholefield and G. Zondagh coming in for P. J. Du Toit and D. Vorster. One is pleased to note that some of the reports give us rather more generous recognition than the week before.

At Coventry the team were much better all round, this of course being due to better condition and as the season progresses one can, without undue conceit, predict still further improvement. The forwards heeled better and in the dashes there was much more abandon. B. C. Scholefield and W. H. Taylor were distinctly good, but in the heavy work few did better than F. J. Biddle.

During the first portion of the game C. L. Steyn and B. C. Scholefield were try-getters. The former from some stirring work on the part of the backs, who handled with remarkable accuracy and all the while at a speed that fairly non-plussed the home team. Scholefield gained his try by securing the ball from some close work quite near the line and going over with an amount of ginger most refreshing to see. J. G. Van Schalkwijk converted both tries with ease. J. Mallam, a Coventry threequarter, had previously gained an unconverted try so that the interval found us with a small margin in hand.

W. H. Taylor gained an easy 3 points after ends were changed, but no conversion followed and before the end G. R. Mostert got over, after a very fine run, led up to by the excellent passing of the back division. The backs altogether, getting plenty of the ball played a very fine game indeed, and the determination of Mostert, combined with his speed, earned him generous applause on the part of the spectators. Final score, Guy's 2 goals 2 tries (16 points) to 1 try (3 points).

Guy's Team.—W. Badenhorst, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, G. R. Mostert, F. Bekker, E. L. Sprong, W. H. Taylor, E. E. Neser, F. J. Biddle, P. G. Harvey, G. Zondagh, F. G. Hutchinson, B. C. Scholefield and N. M. Holloway.

Change of Address.

Frederick Walter Day, L.D.S.Eng., D.D.S.Pena., "East View," The Broadway, Thorpe Bay, Essex.

John D. Malcolm, Whitmore, Chulmleigh, North Devon.

A. M. Zamora, M.Ch., F.R.C.S., 4, Devonshire Place, Upper Wimpole Street, W.1.

J. Aston Martin, c/o Secretary, Church Missionary Society, Lahore, India.

W. Makeig-Jones, Conisboro, Seaton, Devon.

P. P. Laidlaw, 31, Wentworth Road, Golders Green, N.W.

E. L. Elliott, Stokenchurch, High Wycombe.

Eliot Blake, Oakley House, Acle, Norfolk.

W. H. Grace, M.D., M.R.C.P.Lond., "Richmond Lodge," Boughton, Chester.

W. A. Cooper, L.D.S., 31, Talbot St., Southport, Lancs.

Appointment.

W. H. Grace, M.D., M.R.C.P.Lond., to be Pathologist to the County Asylum, Upton, Cheshire.

Birth.

HENRY.—On September 1st, 1922, at Reigate, to Frances, the wife of C. J. Henry, of 79, King William Street, E.C., a daughter.

The Sciences.

BIOLOGY.

The Biology course is primarily intended to be the students' introduction to the science of medicine, and must be regarded as the study of living things in many forms and from various aspects rather than the accumulation of facts about a number of plants and animals. In other words, it is intended as a training in the acquisition of a point of view rather than a stock of facts. Incidentally, also, the student learns a language which is largely his means of expression afterwards. The practice of the Biological Laboratory should give him a facility in the use of scalpel and scissors and a knowledge of methods of preparation and staining of tissues which are the arts of the Dissecting Room and the Histological Laboratory. Lastly, a thorough acquaintance with the vertebrate types should be a great help to him in obtaining an intelligent knowledge of human anatomy.

Cases of instruments are placed on view which include all those afterwards required in the Dissecting Room. A microscope is needed from the beginning, and the student is warned against buying an instrument which will be a handicap to him throughout his career. The difference in price between a good and a bad instrument is only a few pounds. All second-hand microscopes should be submitted to the Demonstrators for inspection and examination of lenses before the purchase is completed.

CHEMISTRY AND PHYSICS.

The student is often tempted to regard the study of Chemistry and Physics as one of very little use when once his preliminary examination is passed; but he will find in his study of the sciences of Physiology, Pharmacology and Pathology that a proper understanding of Chemistry and Physics is invaluable and essential. That this is so, is now fully recognised in the curriculum of the London University which should be carefully studied by every London student.

The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of the second winter, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third winter, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required. but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

The importance of practical work cannot be too greatly emphasised, and lectures and books can but supplement work done in the laboratory. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open from 9 a.m. to 5 p.m. from Monday to Friday, and from 9 to 1 on Saturday, and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought. "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

ANATOMY.

The primary object of dissecting is to render oneself familiar with the structures of human anatomy and their relationships one to another. A good knowledge of human anatomy is essential to the medical student, owing to the great scope for application of this knowledge which is provided by medicine and surgery, and it is no exaggeration to say that the better a man knows his anatomy, the more likely is he to succeed in these subjects. By handling and tracing the structures exposed in dissections, the student is enabled to form mental pictures which greatly exceed in value the plates and diagrams to be found in books, and it cannot be emphasised too much that the knowledge obtained by dissecting is more thorough, more lasting and more definite than the knowledge obtained from text-books, however good the latter may be.

In addition, dissecting trains the fingers and develops the sense of touch, and that delicate muscle sense which is so necessary to aid the eye in carrying out a delicate manipulation.

The basis of anatomical knowledge is a thorough acquaintance with the bones. These can only be learnt by handling the bone and making out each point on it as the description in the book is being read. Hence it is very desirable to possess a half skeleton. (This may be had from Mr. Hancock, the Senior Assistant in the Anatomical Department, who will also supply cases of instruments.)

The man who sits in an easy chair with an open Gray upon his knees and no bones by his side is simply wasting his time.

Men who intend to take the Primary Examination for the Fellowship of the Royal College of Surgeons should attend both the course of lectures for senior students in the second winter session (for times, *vide* notices), and also the special class for the Primary Examination.

Books and Instruments.

The student requires a Manual of Practical Anatomy, in which the structures are described as they are exposed in the course of dissection. The best book for this purpose is Cunningham's Practical Anatomy (3 vols., 12/6 each); it should be read before during, and after each day's work.

In addition, a text-book of Human Anatomy, in which the subject is described by systems, is necessary. Gray's or Cunningham's Text-Book are both good.

Men who think that they may want to take the Primary Examination for the Fellowship of the Royal College of Surgeons will require a book dealing with Embryology and Morphology, and they will find that Keith's book on the subject contains all that is essential.

The following instruments are necessary:—Three scalpels, two pairs of *dissecting* forceps, and two sets of "hooks." No other instruments are required.

Dental Students.

The detailed knowledge which is demanded of the medical student is essential for the dental student only as regards the head and neck and the bones of the skull. Special demonstrations are arranged each term suitable to the requirements for the L.D.S. Examination.

PHYSIOLOGY.

Physiology, which forms the basis upon which scientific medicine and surgery rest, will require the most earnest attention on the part of the student during the short space of two years which he can devote to it, and he will find that his understanding of the medical, surgical and pathological problems with which he will meet later on varies directly with the thoroughness of his physiological ground work. While the reading of some elementary work on the subject, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works by B. Moore and by Foster and Shore, during the first year is undoubtedly useful, yet for most men the practical study of Physiology begins in the first summer session. During this session he attends the classes in Practical Histology which are held three times a week, and for which he will need a microscope, certain mounting materials, and Schäfer's *Essentials of Histology*, which should be carefully studied.

The student should attend the lectures on Physiology (for times, *vide* notices), and also the tutorial classes which are held by the demonstrators. During this time he should read the subject in some text-book such as Starling's *Principles of Human Physiology*, Halliburton's *Handbook of Physiology*, Stewart's *Manual of Physiology*, Howell's *Text-book of Physiology*, or Hill and Flack's *Text-book*. While attending the practical classes held during the winter, the student is advised to read *Practical Physiology* (published by Arnold).

Physiological clinical demonstrations for senior students are held each week.

Candidates for the M.B. of London or other Universities must in addition attend the class in advanced practical physiology held twice a week during the second winter session, and this class should also be attended by men working for the first F.R.C.S. examination.

Those desirous of obtaining a wider knowledge or distinction in the second M.B. examination should supplement the course of reading indicated above with original papers in the *Journal of Physiology*, with parts of Schäfer's *Text-book of Physiology*, *Recent Advances in Physiology and Bio-Chemistry*, edited by L. Hill; *Further Advances in Physiology*, edited by L. Hill; *Principles of General Physiology*, by W. M. Bayliss; and Leathes' *Problems in Animal Metabolism*. Revision classes are held by the Demonstrators during the two months preceding the first F.R.C.S. and the M.B. examinations and should be attended by all candidates.

PATHOLOGY.

When the student has passed the Second Conjoint or M.B. Examination he is about half-way through his medical curriculum, and he should have gained a working knowledge of the functions of the body in health. This knowledge is an essential preliminary to the study of the most important of the medical Sciences, viz., Pathology, or the study of the functions of the body in disease. Throughout his life the student, if he continues to study and practise medicine, must ever keep pathology in the foreground. It is desirable, therefore, that the study of pathology be begun as soon as possible and continued throughout a medical career.

The subject is an exceedingly large one and it is customary to divide it into several sections:—

1. General Pathology.
2. Morbid Anatomy.
3. Morbid Histology.
4. Bacteriology.
5. Chemical Pathology.

Due attention must be paid to each of these branches.

During the first three months' work in the wards the study of pathology is commenced. Three mornings weekly are occupied with lectures on the general principles of Pathology and by practical work in Morbid Histology and Bacteriology. Regular attendance at these classes is most desirable, and the attractions of the Wards and clinical work should not be allowed to interfere with the laboratory studies.

Classes and demonstrations in chemical pathology should be attended during the tenure of the post of Medical Ward Clerk.

It is essential that throughout all ward appointments no opportunity should be missed of continuing the study of pathology. Every man should, as far as is practicable, follow out the pathology of each and every one of his cases. Is a bacteriological investigation made? He should follow it as far as possible. Is a portion of tissue removed for microscopical examination? He should see the section. Is a chemical examination demanded? He should try and see the analysis carried out. He should never miss an autopsy on any one of his cases. He should read up each case as he meets it. Set hours cannot be given for these lines of study, they must be fitted in as time and opportunity permit.

Efforts should be made to see as much practical work and as many demonstrations in pathology as can be arranged. There are very few days when no pathology can be learned. Post-mortems are held nearly every day—Monday, Tuesday, Wednesday, Thursday and Friday at 1.30 p.m., and Saturday at 11.30 p.m. Attendance at these will amply repay the time expended.

Informal classes in pathology are held three times weekly during the October and May terms. These, though primarily intended for M.B. students are suitable for

and should be attended by those sitting for Part I. of the M.B. Cantab. and the Final M.B. of Oxford or London University.

During the later clinical appointments certain students may hold a few pathological posts, such as Student Demonstrator, Assistant to the Demonstrators of Morbid Anatomy, Student Assistant in the Bacteriological Department. One or more of these may be held in turn, and they prove exceedingly valuable from the learners point of view.

There are many books which might be recommended, and what suits one man does not prove attractive to another. MacCallum, "Text Book of Pathology"; Pembrey and Ritchie, "General Pathology"; with Muir and Ritchie, "Manual of Bacteriology," should prove an adequate combination for most purposes. Other books which may suit other tastes and which are good are—Adami, "Principles of Pathology"; Adami and Macrae, "Text-book of Pathology"; Green, "Pathology." For morbid histology Grunbaum "Essentials of Morbid Histology" may be recommended.

When the information in these books proves inadequate, as it is sure to do occasionally, some of the articles in Allbutt and Rolleston "System of Medicine" may be consulted, or references to original papers may be obtained from that work, and from the bibliography in MacCallum, "Text-book of Pathology."

BACTERIOLOGY.

From the preceding paragraphs it will be seen that elementary practical instruction forms part of the work of the newly appointed Ward Clerk, and as such is intimately associated with clinical medicine and surgery, on the one hand, and post-mortem study on the other. From the student's point of view microscopical pathology, which used to occupy some 120 hours compressed into an appointment of three months' duration (Surgical Ward Clerk) is now being extended over a period of six months, and more stress is laid upon the correlation of microbic activity and histological changes.

Bacteriology, although one of the youngest of the auxiliary sciences, has already made a most profound impression upon the theory and practice of both medicine and surgery, and by providing appropriate and specific treatment for bacterial infections has created the demand for exact as well as accurate diagnosis. Consequently, particular attention is devoted in this class to the technique of the various investigations undertaken in connection with the ward work. The student himself stains sputum, pus, and morbid exudates by various methods to demonstrate the associated bacteria. In addition, he is instructed in the practical work of culture and staining methods, and is encouraged to repeat for himself during the intervals between successive classes any observations and experiments previously carried out, in order that he may be adequately prepared to take advantage of the advanced courses which are available during later years of study, and to equip him for the performance in general practice of those more obvious methods of bacteriological diagnosis, which experience has shown are both reliable and valuable. Demonstrations are also given upon the life history of the various organisms pathogenic to the human race and the changes such organisms undergo or produce when they gain entrance to the human tissues.

During February and March of each year a course of lectures is given dealing more technically with the applications of bacteriology to practical diagnosis and treatment. These should be attended at a somewhat later period, since they deal with the various remedial agents (serums and vaccines) which have been elaborated in the bacteriological laboratory for the treatment of disease, together with those facts and theories relating to natural and acquired immunity upon which bacteriological therapy is based.

CLINICAL CHEMISTRY.

A class is held in this subject during the period of first three months medical ward clerk, forming part of the course in pathology. Students are recommended to make an early acquaintance with this subject in order that they may carry out investigations of this nature on their own cases, for which purpose accommodation is provided both in the clinical laboratory and in the laboratory of clinical chemistry.

MEDICAL WARDS.

To each medical ward clerk is allotted a certain number of beds, and he is expected to examine, and write full reports on all patients who are admitted into these. Occasionally it so happens that a patient is too ill to be examined except by the house-physician and physician, or that a case dies before the ward clerk has had an opportunity of seeing it. Under these circumstances he should obtain the history, and an account of the symptoms, physical signs, and progress of the case from the house-physician, and should base his report on these data. It cannot be too strongly insisted that a report, however brief, must be written on every case, and it is of the greatest importance that the diagnosis and remarks made by the Physician should be entered at once into the report. Moreover, any errors detected by the Physician or Registrar in the original report should be immediately corrected. In the event of a patient dying the ward clerk must obtain the abstract of the post-mortem findings, and carefully enter it up, and it need hardly be said that all clerks should make every effort to see the post-mortem examination on any case they may have seen during life.

The medical wards are open to clerks from 10 till 12.30 in the morning, and from 1.30 till 6.30 in the evening. The Registrars begin their rounds at 10.30, and by that time a clerk should at least have full notes of the history of any new patient who may have been admitted into one of his beds; and he should have a full report in readiness for the Physician in the afternoon. Ward clerks should realise that they are expected to know the details not only of their own cases, but of every patient under their Physician. It is no excuse to plead ignorance because "this is not my case." If only a clerk will take the trouble to make himself conversant with each case in this way, he will find at the end of his six months that an enormous amount of clinical material has passed through his hands, and he will probably have acquired enough knowledge of medicine to enable him to pass the Conjoint Final with but little additional reading. But so many men waste their time through sheer laziness in the medical wards, never realising that they are throwing away experience which would prove invaluable to them later on.

An hour spent in the wards after tea three or four times a week will give opportunities, not only for going over cases and writing up reports, but also for seeing the house-physician tap chests and abdomens, etc. The treatment, too, which each case is receiving, may well be studied at this time.

With the present shortage of beds, no opportunity of gaining clinical experience should be missed, and many of the most interesting and important medical cases can be seen at Out-Patients. Nothing is more valuable than seeing the new out-patients, writing up their history, examining them and making a diagnosis, before they are seen by the physician.

As regards reading, the best method is to study the text-book account of each disease as one comes across it in the wards or in discussion, and afterwards to compare, if possible, the text-book description with the symptoms and signs presented by the patients. At the same time, the most important medical journals should be read regularly, for by this means only can the student keep himself in touch with modern work. The *B.M.J.* and *The Lancet, The Quarterly Journal of Medicine,* as well as the *Journal of the American Medical Association,* are especially recommended.

Books that may be recommended are the following:—The well-known text books by Osler and Dr. Poulton's revised edition of Taylor, "Medical Diagnosis," by Latham and Torrens, and "Auscultation and Percussion," by Gee. For second three months ward clerks the most important monographs in Allbutt's or Osler's "System of Medicine," and Campbell Thomson's "Diseases of the Nervous System," will prove valuable and interesting reading. For laboratory work Hutchinson and Rainey's "Clinical Methods," or Dr. French's book will be useful.

With the large number of students at present on a firm, it is difficult for a man to get the same clinical experience as before the war. It is hoped that this state of affairs may be improved in January, by making use of some of the beds at Bermondsey Infirmary. The scheme has not yet been sanctioned by the Governors, so that it is entirely provisional, but it is hoped that ninety beds, mainly of selected cases, will be available. The teaching would be by the Staff of Guy's Hospital, and in every way the routine of the appointment would be made as similar to the appointments as possible. It would be a voluntary appointment for second three months ward clerks. Out-Patients and Post-mortems would be done here as at present. If the scheme is approved by the Governors its success will largely depend on the keenness of the clerks who apply for the appointment. They will certainly not lack clinical experience of a most interesting and valuable kind.

SURGICAL WARDS.

The appointment of Surgical Ward Clerk is held for three months. It is the first, and possibly the best, clinical appointment. The ward clerk has a very definite responsibility, not only in recording the history and progress of his cases for future reference, but also in making observations which may be of vital importance. In this way the knowledge he acquires is the more certainly impressed. Each clerk is attached to a surgical unit, and works in the wards under the direction of the surgeon to whom he is attached and the registrar of the unit.

During this appointment the student attends a course in elementary pathology and pharmacology, and receives a grounding in the principles of disease and treatment. At the same time he cannot be too strongly recommended to take every advantage of his opportunities to gain an insight into that practical work which will stand him in good stead, not only as a surgical dresser, but throughout his professional career. He should make a point of spending all his available time in the Surgery during "take in" week, and of seeing major and minor operations and even dressings whenever possible.

The responsibility of writing careful reports is too obvious to labour; no clerk with a grain of common sense will regard a surgical report merely as an educational exercise for his own benefit.

Two further periods of three months are devoted to the appointments of Surgical Dresser. The work of a dresser is perhaps of more importance at Guy's than at any other hospital, and the advantages to be gained are correspondingly greater. A dresser has only to realise this to prove himself worthy of the trust and reap the benefits.

The most junior clinical student has a definite status in the wards, and he will find his opinion as an anatomist or physiologist treated with the greatest respect. That he should occasionally be called upon to do some of the "dirty work" is inevitable; but no reflection is cast thereby on his standing.

We have only briefly indicated the main points in the work of a surgical dresser. He will receive a copy of the "Standing Orders" relative to this and each other appointment he may hold. The hospital expects, and rightly insists, that he shall pay strict attention to these orders, since he is no longer an irresponsible student, but for the time being one of the cogs in the wheel on whose integrity the smooth running of the hospital depends. With growing knowledge comes growing responsibility, and he must show himself worthy of the trust reposed in him.

THE OBSTETRIC DEPARTMENT.

After finishing appointments in the Medical and Surgical Wards the student is posted to the Obstetric Department for six months. During the whole of this period he is also attached to the Physician for Children's Diseases. The Obstetric Dresser is responsible for case-taking in the wards and at Out-Patients, assists at operations, and during one month acts as Extern in the Maternity Charity. The Department has twenty-two beds reserved for gynæcological cases and eleven beds for the reception of cases presenting complications in pregnancy, labour and the puerperium. As an intervening link between the Obstetric and Children's Departments is the Salomons Centre, in which the health of mothers and infants is fostered by the practice of preventive medicine. The scope of the work done outside the wards is indicated by the fact that last year 2,500 attendances were recorded at Obstetric Out-Patients, while 2,600 women were attended in confinements in their own homes.

With this wealth of clinical material available it should be possible for every student to obtain a

sound knowledge of methods of diagnosis and treatment founded on no small experience. It must be confessed that this desideratum is not always attained and the cause lies partially in a fundamental defect in the medical curriculum. Passed through the hands of a succession of specialists, the student is apt to develop a compartmental mind: the filling up of a buff transfer slip is all the consideration which he is prepared to give to a case with gynæcological symptoms. It cannot be too strongly urged that a wider outlook on Medicine should be cultivated, and that the study of the symptoms of diseases peculiar to women should be begun from the outset of a student's clinical training. The man entering the wards who hopes to become a complete doctor should include among his initial purchases a book on Gynæcology and should make a point of attending the systematic lectures given by the obstetric surgeons during the summer session. He should also avoid no opportunity of acquiring the "tactus eruditus" so essential to the diagnosis of pelvic disorders. The inherent impossibility of permitting a class of students to examine women one after another renders it imperative that this experience should be gained over a considerable period of time.

The study of midwifery he may well leave until e becomes an obstetric dresser, and it is hoped that in the near future he may be provided with still greater facilities for learning this art.

THE CHILDREN'S DEPARTMENT.

Physician-in-Charge, Dr. Cameron.

Chief Clinical Assistant, Mr. A. A. Osman.

In-patient accommodation.—Dr. Cameron has under his care 14 cots in the Children's Ward. On two days in the week, at present on Tuesdays and Thursdays at 2 p.m., Dr. Cameron goes round the ward and gives clinical instruction.

Out-Patient Department. — Children under 10 years of age are seen in the Children's Department at Out-Patients on Mondays, Wednesdays, and Fridays from 9.30 until 1 o'clock. Dr. Cameron attends on Mondays and Fridays at 10 a.m., when clinical instruction is given.

The Salomons Centre for the care of the mothers and children of the Midwifery Charity is now completed.

NEUROLOGICAL DEPARTMENT.
MEDICO-NEUROLOGICAL CLINIC.

The arrangements for the Medico-Neurological Clinic for the Winter Session are not finally settled, but they will be approximately as follows:—

(1) *Elementary Ward Teaching at 2 p.m.* Monday and Friday, Dr. Hurst; Thursday, Dr. Hunt; Monday, Dr. Symonds (Neurological).

(2) *Advanced Ward Teaching for post-graduates only at 10.30 a.m.* Tuesday, Dr. Hurst and Dr. Symonds; Thursday, Dr. Hurst and Dr. Hunt (Neurological).

(3) *Clinical Demonstrations at 12 noon.* Mondays, Medical, in turn, Dr. Hurst (gastro-intestinal), Dr. Hunt (circulatory), Dr. Marshall (tuberculosis), and Dr. Barber (dermatological); Fridays, *Neurological*, Dr. Symonds, 1st, 3rd and 5th Fridays, Dr. Hurst, 2nd Wednesday, and Dr. Craig, 4th Wednesday; Fridays, *Medico-Surgical*, Dr. Hurst or Dr. Hunt with a surgeon or specialist.

(4) *Out-Patients.* Medical, Tuesday, Dr. Hunt; Neurological, Wednesday and Saturday, Dr. Symonds.

THE DERMATOLOGICAL DEPARTMENT.

Out-Patient Days.—Tuesday, 9.30 a.m. (children), 10.30 a.m, (adults). Thursday, 9.30 a.m.

The Physician in charge of the Department also sees selected old cases, which require special investigation or treatment, on Wednesdays at 1.30 p.m., and anyone desiring to carry out a research in the Department may arrange with patients to attend at this time for the purpose of investigation.

Wards. There are three male and three female beds in the Medical Wards for dermatological cases requiring careful supervision or treatment in bed.

Instruction in the diagnosis and treatment of diseases of the skin is given in the Out-Patient Department, and clinical demonstrations on selected cases are held from time to time.

THE AURAL AND LARYNGOLOGICAL DEPARTMENT.

This Department is organised on the unit system. There are two units, one under the care of Mr. Mollison, the other of Mr. Layton. Patients are seen in the Out-Patient Department, admitted when necessary to the special wards, Ruth and Barnabas, and returned to the Out-Patient Department. This arrangement allows members of each unit to follow up the cases. Mr. Mollison's firm sees out-patients on Tuesdays and Fridays at 12 noon, Mr. Layton's firm on Mondays and Thursdays at 12 noon.

Dressers are appointed to the respective firms, and have every opportunity of becoming expert in the technique of examination of the ear, nose and throat, and gain experience in diagnosis and treatment. Large numbers of school children are seen, and about 1,000 minor operations are performed in the Out-Patient Department a year; of these the great majority are for the removal of tonsils and adenoids: these operations are performed by the dressers under the supervision of the Surgeon or the Clinical Assistant.

Eighteen beds are now allotted to the Department and each firm operates twice a week. Mr. Mollison and Mr. Layton "take-in" during alternate weeks and emergencies are admitted under the care of the firm on duty.

THE OPHTHALMIC DEPARTMENT.

The Ophthalmic Department of the Hospital is in charge of the two Ophthalmic Surgeons. They are helped by two Assistants, two House Surgeons and Dressers. The dressers are appointed four times a year for a period of three months, and assist the Surgeons

at Out-Patients and at operations, and are responsible for the recording of the cases both in the wards and at Out-Patients. The Ophthalmic Department is an open field for any student to explore as far as he is willing and able, the amount of clinical work being sufficiently great for him to see all the more ordinary and common diseases of the eye in the space of three months.

The student will soon find that he is quite unable to form any opinion of his own, on an ophthalmic case, until he has mastered the use of the ophthalmoscope and can readily and accurately decide what is the refraction of the eye, and if the "fundus oculi" is healthy and normal. The theory of retinoscopy can be taught and is simple; the practice, however, requires constant application by the student before he can hope to obtain any sort of facility in it. The difficulties are mainly initial ones, and any time and trouble expended in mastering them will well repay any man in after life when he has qualified and is in practice.

The Ophthalmic House Surgeoncy is one of the most important in the Hospital, as the Ophthalmic House Surgeon is not only in charge of the Ophthalmic beds, but also of Ear, Nose, Throat, and Orthopædic beds, so that his experience is wide and his responsibility great.

THE ORTHOPÆDIC DEPARTMENT.

The Orthopædic Department comprises a large out-patient clinic and ten beds devoted to patients suffering from deformity. Out-patients are seen on Monday and Wednesday afternoons, and in the Out-Patient Department the student will meet with every variety of deformity, congenital and acquired. Considerable facilities are afforded for experience in the relief and cure of all chronic diseases of bones, joints, muscles, etc. Instruction in the principles and most modern practice in the use of appliances, plaster technique, and the more useful forms of physio-therapy is given by Mr. Trethowan, the Orthopædic Surgeon, and Mr. Todd, the Orthopædic Registrar. Numerous operations of a minor nature are done, such as manipulations for stiff and painful joints, correction of mis-shapen and ricketty limbs, correction of scoliosis, and immobilisation of tuberculous joints.

The in-patient beds are devoted to the most serious operative cases, such as extensive tendon transplantations, correction of mal-united fractures, bone-grafting, the making of new joints, etc. Guy's is a pioneer in possessing an excellent workshop for the manufacture of every form of splint and appliance.

It is in the Orthopædic Department that the principles underlying the mechanical disabilities of the limbs and spine are emphasised and their explanation made clear, and the experience to be gained here is invaluable. The great utility of orthopædic surgery has become evident to very many during the war.

THE GENITO-URINARY DEPARTMENT.

Students acting as Dressers in this Department have excellent opportunities of acquiring knowledge which will be useful to them in actual practice and examinations. Out-patients are seen on Tuesday and Friday afternoons.

There are nine in-patient beds, seven in Cornelius Ward and two in Queen Ward. Students should realise that their attendance at this out-patient department, though not compulsory, is very necessary, as is evidenced by the very advanced state of disease in which some patients arrive for examination.

THE MASSAGE DEPARTMENT.

The New Department is now in full working order, and patients are treated between the hours of 2.30 p.m. and 4.30 p.m. on Mondays, Tuesdays, Thursdays and Fridays, and between 9.30 a.m. and 12 a.m. on Wednesdays and Saturdays.

Clinical Demonstrations are given at 2.30 p.m. on Mondays by Dr. Hunt, Physician in Charge, and at 10 a.m. on Wednesdays and Saturdays by Mr. Trethowan, Surgeon in Charge.

The point of interest to Medical Students is to see the work carried out on Patients by Massage and Medical Gymnastics. A large variety of cases are being treated daily which include fractures, stiff joints, dislocations, nerve injuries and disease, lung and heart disease, congenital conditions, and poor development in Children, &c. Students will find interest in following some investigations which are being carried out under the direction of Dr. Hunt, and those who wish to attend in this section of the Hospital should apply to him.

THE TUBERCULOSIS DEPARTMENT.

(Dr. Marshall).

The Tuberculosis Department is a reference department for out-patients suffering from disease of the chest. Patients attend on three days in the week, Tuesday and Friday afternoons and Wednesday evenings. In suitable cases arrangements are made for admission to sanatoria. The patients return to the Out-Patient Department after leaving the sanatorium. The Department provides extensive opportunities for studying methods of investigating early and doubtful cases of pulmonary tuberculosis, also for observing special forms of treatment such as Artificial Pneumothorax.

PRACTICAL PHARMACY, MATERIA MEDICA, AND DISPENSING.

One of the many important things all medical students must know is how to write a prescription. It may even be necessary for the majority, when qualified, to be able to dispense the same. All students, therefore, would be well advised to acquire as much knowledge of the subject as they can.

The student is taught, practically, how to dispense the different medicinal preparations; he learns to write prescriptions, due regard being paid to doses and incompatibilities.

The recognition of crude drugs, their active principles and preparations, form part of the course, which covers the syllabus of the Practical Pharmacy of the Conjoint, the Intermediate M.B.Lond., and the Third M.B.Camb.

DENTAL SCHOOL.

The *Dental Student is supplied at the Medical* School Office with the Prospectus, Standing Orders, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully read in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Notices regarding the time and place of Lectures are to be found posted up at the main entrance of the Dental Department.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

It is inadvisable to purchase instruments before they are required. Instruments for prosthetic work are required for the B.D.S. course at the commencement of the 2nd year, and for the L.D.S. course at the commencement of the 1st year. Clinical instruments are required for the B.D.S. course at the commencement of the 5th year, and for the L.D.S. course at the commencement of the 3rd year.

Among the various depôt at which instruments may be purchased are the following:—Claudius Ash, Sons & Co., Broad Street, Golden Square, W.C.; Dental Manufacturing Co., Alston House, Newman Street, W.; and Cottrell & Co., 15, Charlotte Street, W. 1.

The course of study for the B.D.S. London covers a period of five years, of which the first year consists of Physics, Inorganic Chemistry, and Biology. The second year is occupied with the study of General and Dental Anatomy, Physiology, Dental Histology, Pharmacology and Dental Prosthetics. The study of these subjects is also continued in the third year, together with Pathology, Bacteriology, and Surgery. Clinical work in the wards, Surgery, Medicine, Anæsthetics, Pathology, and Bacteriology, together with Dressership in the Extraction Rooms, Dental Metallurgy and Dental Prosthetics forms the fourth year's work, and the fifth year is occupied by purely Dental subjects, these being Clinical work in the Conservation Room, Orthodontics, Operative Dental Surgery, and Dental Surgery and Pathology.

First and second year students for the L.D.S. have a simple routine to follow. Their work is confined chiefly to Dental Prosthetics, but Chemistry and Physics and Dental Metallurgy are also studied and should be passed, the first two subjects during the first and the third during the second year.

Third and fourth year students for the L.D.S. commence the clinical courses with a two months' period of probationary work upon the phantom head. The operative course, conducted by a staff demonstrator, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These operations upon the dummy form an excellent ground work in operative dentistry.

Thereafter the course of work consists in holding and diligently carrying out the work of the following appointments:—Clinical Clerk in the Conservation Room; *Probationary Dressership in the Conservation Room; *Dressership in the Conservation Room; *Dressership in the Children's Department; Dressership in the Ordinary Extraction Room; Dressership in the Gas Extraction Room; Casualty Dressership; Clerk to Anæsthetist.

A student, apart from those holding the post of Assistant Dental House Surgeon or Clinical Assistant, is not allowed to work in the Conservation Room unless he holds one of the appointments marked *.

The time varies, according to whether the course for the B.D.S. or L.D.S. is being taken, at which a student will come into actual contact with Hospital patients, but he should always endeavour to be punctual in his appointments with them. There is nothing more irritating and annoying to a patient than to be kept waiting unnecessarily; it also delays to a very great extent the easy working of the Department. Further, the student should remember that the cultivation of a courteous and gentle manner towards all patients will become in the future probably the greatest asset in his private practice.

Dental students will profit by following the practice of the Special Departments of the Hospital, *e.g.*, Eye, Throat, Ear. They will also have numerous opportunities of observing the more remote effects of dental disorders in the General Wards and Out-Patient Department.

Students in difficulties about their work and needing advice are invited to consult the Dean, Sub-Dean, Resident Dental Officer, or any other member of the Staff, who will be pleased to do what they can to promote the interests of students.

OSTEOLOGY.

The question of the purchase of bones is always an important one. Millikin & Lawley, in the Strand, make a speciality of supplying the medical student with this part of his equipment.

BOOKS.

The student who wishes to obtain his books at once should not take the first he sees on any particular subject, but would be wise to consult his demonstrators first. The number of text books is very large, and the choice is a difficult matter to the inexperienced. Roughly speaking, second-hand books are very seldom worth anyone's while to buy, chiefly because medical science is progressing so rapidly that new editions are constantly being published.

The number of publishers of books for medical students is great. Messrs. Churchill publish Taylor, Jacobson, Goodhart, Fagge, and many other well-known works. Messrs. Macmillan publish Allbutt, Foster, and a great number of first-year books; Messrs. Longmans, Green & Co., publish the famous Gray's Anatomy. Mr. H. K. Lewis, 136, Gower Street, publishes a number of medical books, and has also a medical circulating library which is valuable to students who wish to see all the latest books. Mr. Murray also publishes many well-known medical books, as also do Smith, Elder & Co., Philip & Son, Cassell & Co., Nisbet & Co., and Baillière Tindall & Cox.

All books can be obtained from Mr. H. H. Grattan, in Borough High Street, who is the "official bookseller" to the Hospital. Many well-known books he can supply over the counter; any others desired he will have in an hour or two.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE appeal for collectors which was issued before the Hospital Flag Day of October 6th met with a gratifying response, the effort to collect collectors being so successful at Guy's that 500 boxes were sent in at the end of the day. Of these, 350 were from students and 150 from the ladies who so kindly helped in the work.

We understand that numerous barrel-organs and an elephant (in two parts) were participators in the proceedings. We are not yet quite certain, from the various accounts which have reached us, whether the animal danced to the strains produced by the massed barrel-organs, before they dispersed to their several stations. But we can well imagine that such a performance would add to the number of onlookers—and therefore possible donors—especially if the faithful quadruped danced upon its hind legs.

About £1,350 was collected by the Guy's workers, the average thus being over £2 14s. per box—a result upon which all who assisted may well congratulate themselves.

It is pleasant to note that our friends across the road, Messrs. Down Bros., who were watching from the windows of their establishment, were moved by what they saw in St. Thomas' Street to send in two cheques of £10 10s. each to the representatives at Guy's of the Hospitals of London Appeal Committee. One was from Mr. Arthur Down, the other from the firm of Down Bros.

WE publish in this issue several accounts of Rugby matches, the usual reports of our indefatigable Mr. Rist.

There is no doubt now that the 1st XV will be as great a success as it was in the past three seasons, and that the brilliance of the team in the opening matches is but the prelude to another great Rugby season for the Hospital.

One of the great sporting events of the season is the Rugby match which has been arranged between the Nomads and the Staff. This will take place, it is hoped, on Wednesday, October 18th, at Honor Oak Park, although the arrangements are not yet absolutely definite. The past performances of the Nomads lead one to expect a very high standard of play in this match, although they will meet a formidable obstacle in the weight of the Staff.

Supporters of either team should watch the Notice Board in the Colonnade.

We have heard that the Secretaries of one or two of the constituent clubs of the Clubs' Union, are complaining that some players who should turn out for the Hospital are playing for other clubs. We cannot quite understand the point of view of a man who prefers playing for a non-hospital team to playing for his hospital. As far as most men are concerned, we are sure that membership of any Hospital team, however junior, involving, as it does, playing in a team with Hospital friends, is regarded as preferable to membership of an outside team.

Those who are unable to get a game as often as they would wish have certainly an adequate reason for trying to get more outside, but we do not think that those who are needed for first teams should desert us as, apparently, some are doing.

THE new specimens received by the Museum of the Royal College of Surgeons, during the year, will be on view in Room I of the Museum from October 9th to November 10th, 1922.

During October a series of Demonstrations of specimens will be given in the Theatre of the College in Lincoln's Inn Fields. Details will be found on p. 427.

There is no need to emphasise the interest and value of these lectures given by Sir Arthur Keith and Professor Shattock. Men going up for their finals, particularly the B.S. and Fellowship, would do well to attend them, and while at the College they would have an opportunity of visiting the exhibition of new specimens. As the Demonstrations are held at 5 p.m, it should be easy to attend them.

A POST GRADUATE course of lectures on diseases and pathology of the nervous system, including lectures, demonstrations, and out-patient clinics, will be held at the National Hospital for the Paralysed and Epileptic, Queen's Square, Bloomsbury, W.C. 1, from October 9th to December 6th, 1922. Those who desire to attend the course can obtain fuller details on consulting the notice outside the Medical School Office.

GUY'S men will be interested to note that the address to Westminster Hospital Students at the commencement of the new academic year was given by Mr. G. T. Mullally, now assistant surgeon at that hospital.

The subject of the address was "The Art of Medicine."

A *résumé* of the address is given in the *British Medical Journal* of October 7th, 1922, and it is reported in full in *The Broadway (Westminster Hospital Gazette)*.

WE congratulate the Hockey team on their success in the match against the R.M.A., Woolwich, whom they defeated by 3 goals to 2.

THE inaugural meeting of the Physical Society, which took place just as we were going to press, and to which it is impossible to allude in this issue except very briefly, was very well attended, and the men who filled the Anatomical Theatre spent a most enjoyable hour listening to an address by Sir Charters Symonds, on "Some Guy's Surgeons and their Writings."

Sir Charters Symonds' enthusiasm is infectious. The applause which greeted him after he had delivered his address left no room for any possible doubt whatever as to the pleasure he had given his audience.

A report of the meeting will be published in our next issue.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I have read Dr. Geoffrey Marshall's lecture on Tuberculosis in the issue of the GAZETTE for September 16th, and must join issue with him over his sweeping condemnation of Tuberculin. He states that there is no proof of any curative effect. I would refer him to the published statistics in Dr. Carnac Wilkinson's book, "Tuberculin in the Diagnosis and Treatment of Tuberculosis," and I would also ask him to consider these further statistics. Of cases treated under the Sanatorium Benefit Insurance Act, during the years 1910, 1911, and 1912, 28 per cent. were alive at the end of four years.

Of the cases treated with Tuberculin at the Lambeth Tuberculin Dispensary during the same years 64 per cent. were alive at the end of ten years. Both series of cases were in the first or second stage.

It is impossible to refute such a loose statement as "numerous instances of quiescent foci being lit up, with fatal result, by injection of a large dose of tuberculin," unless definite evidence in each case is produced clearly indicating the attendant circumstances. Tuberculin, like other remedies, is, of course, of little avail unless properly administered, its haphazard use can only bring this treatment into discredit. In my opinion Professor Koch's method, as expounded and practised by Dr. Carnac Wilkinson for more than twenty years, has more than proved itself by its results to be the only right method of using Tuberculin.

My own experience during the last three years has made my conviction firmer that in Tuberculin properly used we have a remedy free from danger, of great value in diagnosis, and in a very large percentage of cases capable of immunising the patient.

It would be interesting to hear what methods were adopted in those cases which Dr. Marshall quotes as being so dangerous and unsatisfactory.

Tuberculin has been condemned by those who have used it in a wrong manner.—Yours truly,

ROLF CREASY, Junr.

36, Weymouth Street, W. 1.

Publications Received.

The Antiseptic, St. Bartholomew's Hospital Journal, College of Nursing Bulletin, Burma Medical Times, Hospital and Health Review, Indian Medical Record, St. Mary's Hospital Gazette, Medical Journal of South Africa, Middlesex Hospital Journal, Nursing Times, The Stethoscope.

Notices.

Liverpool and North-Western Guy's Reunion Dinner.

The Annual Dinner will be held at the North-Western Hotel, Lime Street, Liverpool, on Wednesday, November 8th, next, at 7.30 p.m. Will all old Guy's men who wish to attend please communicate with me. Price of Dinner 12s. 6d. (exclusive of wine), to be paid at the dinner. Music.

HORACE MATHER, Hon. Sec.

73, Rodney Street, Liverpool.

Royal College of Surgeons of England.

MUSEUM DEMONSTRATIONS.

The following demonstrations of specimens in the Museum will be given in the Theatre of the College in Lincoln's Inn Fields.

The demonstrations are open to Advanced Students and Medical Practitioners.

October Course, 1922.

Friday, 13th October, 5 p.m.—Sir Arthur Keith. Specimens illustrating the effects of Castration in Man.

Monday, 16th October, 5 p.m.—Prof. Shattock. Specimens illustrating the anatomical results of Inflammation.

Friday, 20th October, 5 p.m.—Sir Arthur Keith. Hydrocephaly. Illustrative specimens to be shown, and recent investigation on the nature of the disorder discussed.

Monday, 23rd October, 5 p.m.—Prof. Shattock. Specimens illustrating Carcinoma.

Friday, 27th October, 5 p.m.—Sir Arthur Keith. Results following resection of the bowel, illustrated by experimental work done by Mr. Tyrrell Gray on Cats.

Monday, 30th October, 5 p.m.—Prof. Shattock. Specimens of Foreign Bodies.

S. FORREST COWELL,
Secretary.

Change of Address.

P. D. Scott, 183, Maida Vale, W.9.

W. E. Tanner, 48, Philbeach Gardens, Earl's Court, S.W. 5.

Lieut.-Col. S. A. Ruzzak, I.M.S., c/o Messrs, King, King & Co., Fort, Bombay, India.

J. S. Vogwell, L.D.S., Eastgate House, Louth, Lincs.

R. B. P. Lansdown, "Maycroft," Smithamdowns Road, Purley, Surrey.

Two Cases of Pseudo-Hypertrophic Muscular Paralysis.

By Major C. H. REINHOLD, M.C., F.R.C.S.Edin., I.M.S.

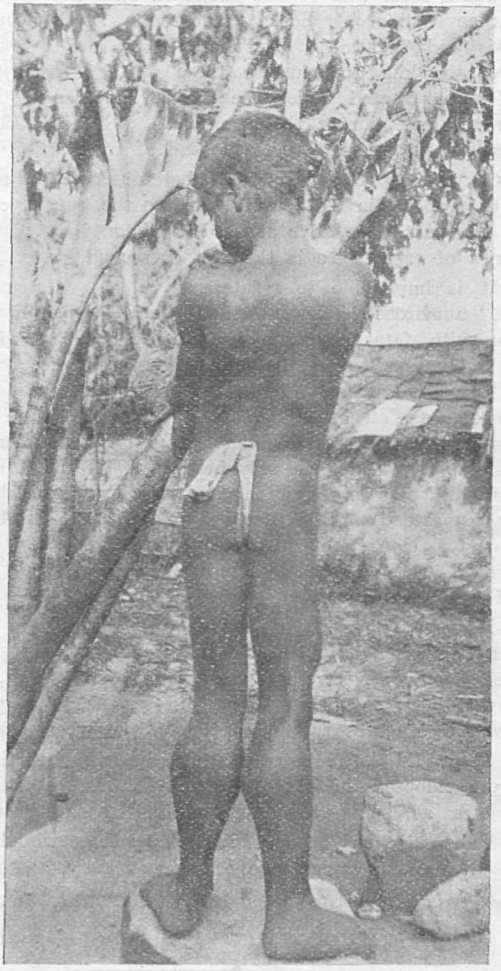
The two cases of this disease illustrated in the accompanying photographs show all the typical aspects of pseudo-hypertrophic muscular atrophy, but

present one or two points of difference which must be my apology for this very incomplete record.

A painstaking enquiry into family history has failed to discover any similar cases in their ancestors or collateral branches.

An elder sister and brother are healthy and a younger brother (aged 10 years) and sister show no signs of the disease.

The elder patient, Raghobir (now 16 years) first showed signs at four years of age. His younger brother, Sheobalak (now 14 years), began to develop the disease at eight years, and in him it has progressed much more rapidly so that he has been unable to stand for over a year; a true atrophy of his muscles is much more marked than pseudo-hypertrophy, although the latter is still to be seen in his gastrocnemei, serratus magnus, and latissimus-dorsi muscles.



The affection of muscles as studied in Raghobir fall into four groups :—

1. Pseudo-hypertrophy—
   - Supra-spinatus.
   - Infra-spinatus.
   - Serratus-magnus.
   - Latissimus-dorsi.
   - Quadriceps Extensor.
   - Calf muscles.

2. Atrophy—
   Deltoid.
   Trapezius.
   Pectorals.
   Biceps.
   Triceps.
   Pronators and supinators of fore-arm.

3. True hypertrophy—
   Lumbar and spinal muscles.
   Gluteal muscles (?).
4. Normal—
   Neck muscles
   Sterno-mastoid.
   Abdominal muscles.
   Lumbricals and hand muscles.

Both boys are afflicted with thyroid disease. Raghobir is a cretinous idiot and Sheobalak has a cystic goitre. No other member of the family suffers from goitre, and the youngest brother, aged 10, appears to be a particularly healthy alert specimen of humanity.

It is suggested that there may be some connection between thyroid insufficiency and this disease, although it must be admitted, that goitre is very common in parts of India, whilst pseudo hypertrophic

muscular paralysis is—at least—as rare here as in any other part of the world.

A course of thyroid extract for several months has not stayed the march of this dystrophy in either case as observed for over a year, and they are both slowly, but progressively, getting worse.

I am indebted to my assistant, Khan Sahib Nur Ullah, I.M.D., for much help in following the cases and tracing their histories.

Dihra Dun, U.P.,
August 8th, 1922.

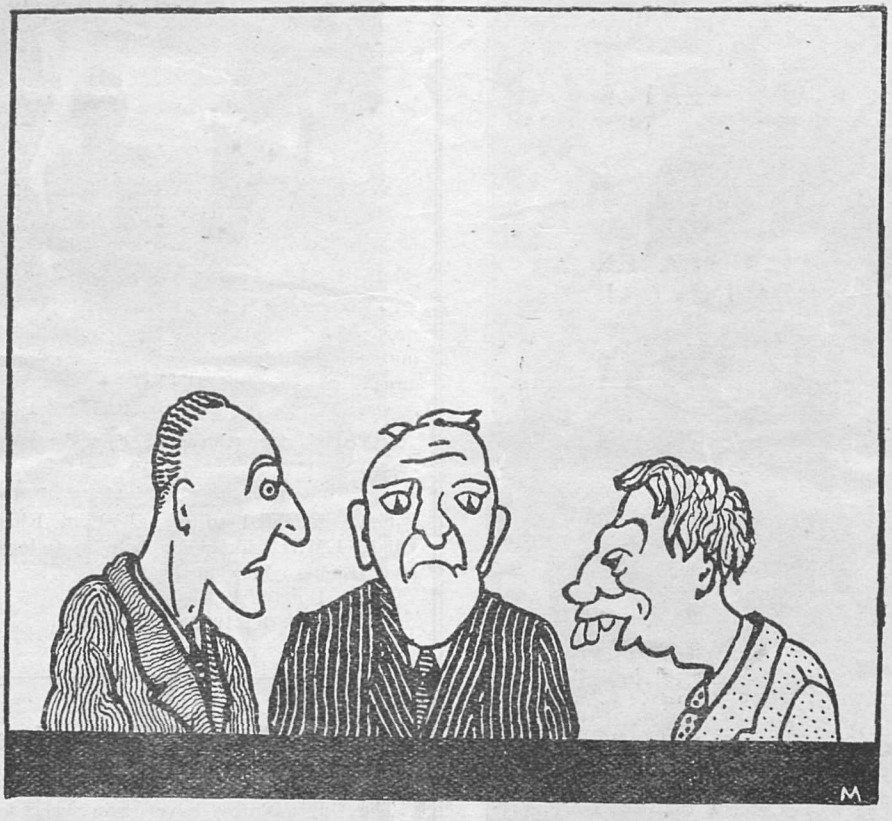
Guy's Nurses' Swimming Club.

The Guy's Nurses have again succeeded in winning an Inter-Hospital Swimming Cup.

The competition took place at the Charity Gala held in the Municipal Baths in aid of the Prince of Wales's Hospital, Tottenham. The "Holmes" Vase is a very handsome Silver Vase presented by the Governors of the Prince of Wales's Hospital to perpetuate the memory of a nurse, very interested in swimming, who died early in 1922. The Vase is to be competed for annually by the Nurses of the various London hospitals.

On September 30th, 1922, the first race took place, Nurses F. Garland, V. Murray, W. Sheppard, and D. G. James forming the winning team from Guy's. Other Hospitals entering were Queen's Hospital and the Prince of Wales's.

A Bedlam Essay in Vers Libre.

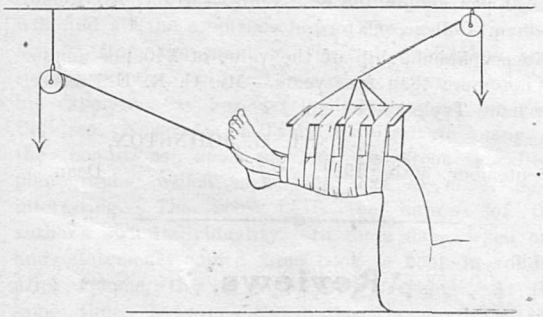


There was a young man in the Park
Who was hit on the head by a stone;
When they asked "Does it hurt?"
He replied, "No, not much,
"But I'm glad it wasn't a differential calculus."

Back Traction for Fractures.

By F. S. DUKES, M.B., M.R.C.S.

Appliances for fractured thigh in children are notoriously unsatisfactory. Suspension acts well only if the fracture is not near the lower end, for it does not allow of flexion of the knee. In a case of double fracture of the femur in a child of 5, nothing would stop the spasms except chloroform pushed fairly deeply. Evi-



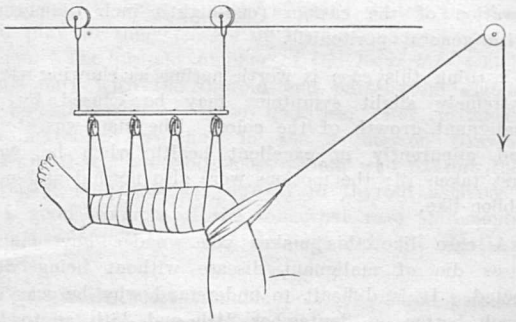
dently the lower fragment tended to flex; she said when suspended that the knee was bent and she couldn't straighten it, and that "the bone was pressing against a chair." An inclined plane was worse; even when she was wide awake the spasms were dreadful to witness.

So, as I was always taught at Guy's that common sense beats all the regulation splints, I used the following arrangement, which acted like magic and produced a perfect result. The usual stirrup extension was raised to 6 feet at the foot of the bed, and another was applied at right angles to it from the head of the bed (where the child lay), by means of flannel loops to the leg below the knee, on a speader. By regulating the ratio between the two weights, all different degrees of flexion, both of knee and hip, can be obtained, and of course the pull depends on the resultant of the total weights.

The advantage of this plan is evident. It leaves the child free to move and to be attended to. The thigh can be massaged (and the result of this is marvellous and almost instantaneous, removing the swelling and heat). Very soon the leg can be moved by the patient to her great comfort and the benefit of the muscles, the weights automatically adjusting themselves to such new position. It requires no attention, and the patient sleeps all night.

The same principle can be applied to fractured leg. A case had fractured tarsus on one side and fractured leg on the other, and was rather helpless in consequence. A block and tackle by which he could lift himself off the bed was of the greatest convenience and comfort.

And I swung his leg on pulleys to a bar which itself ran on a wire overhead. But with such a swing it is not possible to flex the knee much, for the weight of the thigh causes a pressure on the edge of the splint.



But a back traction with flannel or leather above the knee rendered the flexion possible and gave much comfort.

In the case of oblique fracture it might be an important feature in preventing shortening.

This back traction seems to be a new principle of treatment and is, I think, of more than theoretical interest. Its simplicity should commend it.

A Case of Carcinoma of the Splenic Flexure Undiagnosed during Life.

On September 20th I was called to see a ship's painter, aged 59, who was suffering from severe griping pains, especially in the hypogastric region. The history was that he had been in good health until that day. He seemed to think he had an attack of lead colic.

He was rather constipated, and I gave him an ounce of castor oil, and then Tinct. Chlor. c. Morph. to relieve his pain. His bowels acted next morning after an enema, and he gradually improved. There was bile in the urine on the 23rd, and he became slightly jaundiced which, as there was no lead line, made me think it was probably a case of biliary colic. I visited him daily till September 25th, on

which day he was much better; the bowels had been opened twice; the pain had practically disappeared. Unfortunately I did not see him on the 26th. I had an urgent call at 5.30 a.m. on the 27th, when I found him in great pain, which had lasted 15 hours. I thought he had probably had a perforation of the gall-bladder, and sent him off at once to the London Hospital where he arrived in a desperate condition, dying two hours after admission.

The authorities have most kindly given me particulars of the result of the post-mortem, when he was found "to have a large carcinoma of the splenic flexure narrowing the lumen and a punched-out perforation of the cæcum (one-eighth inch diameter) with general peritonitis."

I think this case is worth noting as showing what extremely slight symptoms may be caused by a malignant growth of the colon. The man was stout and apparently in excellent health when he was first taken ill; the motions were also normal and not ribbon-like.

A case like this makes you wonder how many cases die of malignant disease without being detected. It is difficult to understand why he was so much better on September 24th and 25th as to be able to sit up and read a newspaper.* It is also a warning not to be led away by a preconceived idea that because he was a painter he was probably suffering from the effects of lead.

He was so stout that nothing definite could be made out by palpation of the abdomen. There was a good deal of bilious vomiting, which made me decide on biliary colic as the most probable diagnosis.

Another possibility that occurred to me was that it might be a case of acute pancreatitis.

S. G. F.

*The great temporary improvement on the 24th and 25th was no doubt due to the fact that the obstruction had been relieved.

Guy's Hospital Medical and Dental Schools.

Scholarship Awards, Ssptember, 1922.

Senior Science Scholarships.

War Memorial Scholarship of the value of £80.—Mr. J. Gray, B.A., Cambridge.

Open Scholarship of the value of £80.—Mr. N. Burgess, B.A., Caius College, Cambridge.

Junior Science Scholarships.

War Memorial Scholarship of the value of £200.—Mr. J. G. Weston, Guy's Hospital.

Open Scholarship of the value of £100.—Mr. A. Carr, East London College.

Confined Scholarship of the value of £100.—Mr. J. R. C. Spicer, Guy's Hospital.

Arts Scholarships

Of the value of £100.—Mr. S. I. Abrahams, Brighton Grammar School.

Scholarships for Dental Students.

War Memorial Scholarship in Arts of the value of £40 per annum for four years.—Mr. K. S. Keele, Wadham College, Oxford.

Science Scholarship of the value of £40 per annum for not more than four years.—Mr. C. R. E. Freezer, Merchant Taylors' School.

T. B. JOHNSTON,
Dean.

September 30th, 1922.

Reviews.

Aids to Tropical Hygiene. By Colonel R. J. Blackham. Second Edition, 1922. (Messrs. Baillière, Tindall and Cox, London.) Price 4s. 6d.

Colonel Blackham's work is intended primarily, not so much for the ordinary medical student, as for candidates for the Diploma of Tropical Medicine or promotion examinations in the R.A.M.C. He deals with the problems of tropical hygiene mainly from the point of view of conditions in India.

An excellent review is given in fairly concise form of such subjects as water supply, disposal of refuse, the prevention of malaria, and other problems which confront a medical officer in the tropics. There are also brief notes on the morphology of the various insect pests. We are glad to see that the author takes a reasonable view about the administration of so-called prophylactic quinine. Experience in the war showed clearly that the incidence of malaria was not appreciably diminished among troops who were made to take quinine regularly as a prophylactic measure.

It is surprising that in this work we find but little reference to heat stroke, and the means by which it may be avoided. The importance of providing drinking water posts and heat stroke stations might, we think, have been pointed out, especially as the book is intended largely for R.A.M.C. Officers.

We can thoroughly recommend the work, not as a complete text-book on tropical hygiene, but as a useful handbook for revision of the subject.

The Surgical Diseases of Children: a Handbook for Students and Practitioners. By F. C. Pybus, M.S., F.R.C.S. (Messrs. H. K. Lewis & Co., Ltd.) Price 18s.

To have compressed into the small space of 400 pages—a space further reduced by the presence of nearly 300 photographs and drawings—an adequate account of the surgical diseases of children is in itself no mean task. To have done so without producing a "potted" synopsis is even more commendable.

It is impossible in such a short space to give more than a brief outline of the numerous surgical diseases to which children are liable, but the reader will find all the essentials here. The book is written largely from the point of view of comparison with surgery in the adult. The author draws largely on his experience as Surgeon to the Hospital for Sick Children, Newcastle-on-Tyne, to illustrate many of the conditions and provides numerous excellent photographs, which make the text so much more interesting. The book bears the impress of the author's own individuality. In these days, when one finds statements copied from book to book in volume after volume, this is especially refreshing. At the same time, however, the author is anything but unorthodox.

The book will be much appreciated by senior students and general practitioners, as a handy reference book in which to gather in a short time, the essentials of pathology, diagnosis, and treatment of the surgical diseases of children.

Messrs. H. K. Lewis & Co. are to be congratulated on the excellent reproduction of the photographs and radiographs, most of which are original.

Notes on Dental Anatomy and Dental Histology. By T. W. Widdowson, L.D.S.Eng. Pp. 238, 86 Illustrations. (Messrs. John Bale, Sons and Danielson, Ltd., London.) Price 15s. net.

We welcome the appearance of the fourth edition of this book; with each fresh issue it becomes less of a cram book and better fitted for its place among the textbooks. This edition contains a well written description of the theories which have been advanced and of the observed facts of Dental Anatomy. By reproducing figures from various textbooks, and by adding diagrams of his own construction, the author has succeeded in making clear many of the points which students find to be so involved. There are some important omissions from the book; for example, in the description of the calcification of enamel, the later work of Mummery upon the ultimate mode of distribution of the Tomes process finds no place; certain fibres are, moreover, described as osteogenetic fibres, a rash term when applied to an epithelial tissue. Again, insufficient description is given of the important work of Fawcett, of Bristol, upon the development of the mandible. These, however, are but small blemishes, and the student seeking to clarify his mind after perusal of the larger text-books will find in these "Notes" a valuable aid.

The Prescriber. Special Number—Endocrinology I. Thyroid and Parathyroids. October, 1922. Price 4s. 6d.

In dealing with the subject of the endocrine glands it appears to be a privilege of many writers to allow full play to their powers of imagination and speculation. The present number of the *Prescriber* which deals only with the thyroid and parathyroid glands is not deficient in these qualities. For instance, the statement we find in the article on Graves' Disease that "probably most people who exhibit the 'artistic temperament' owe it to thyroid activity" is a good example of the somewhat rash statements so often found in works dealing with the ductless glands.

Perhaps the most valuable portions of the present work are the abstracts of recent literature which appear to be tolerably complete. The special articles which, according to the introduction, purport to give a "complete review" of the subject can hardly be said to do so. For example, in the article on Graves' Disease, by Dr. H. Ewan Waller, the question of surgical treatment is dismissed with the statement that "the surgery of the thyroid gland should be limited to those cases where there are special indications other than the mere presence of Graves' Disease." What these "special indications" are is left to the imagination of the reader. In dealing with Graves' Disease Dr. Waller practically confines himself to a restatement of the well-worn theory that the disease is secondary to focal sepsis either in teeth, tonsils, or other organs. No stress is laid on the fact that patients suffering from the disease are particularly liable to infections of all kinds. This undoubted fact, however, might explain why so high a proportion of Graves' disease patients suffer from attacks of tonsillitis.

In an article on the Influence of the Thyroid in some Acute Infections, Dr. H. Stanley Jones attempts to correlate such different conditions as acute phthisis, acute rheumatism, acute diabetes, syphilis and acute gonorrhœa with hyperthyroidism. On the subject of acute phthisis he writes: "An analysis of the main symptoms of the disease is very suggestive of thyroid excess. The raised temperature, rapid and easily excited pulse, moist perspiring skin, general restlessness and excitability . . etc., are all signs which we associate with hyperthyroidism." Yet all these signs are more or less present with every

acute infection, and a good many of them even with ordinary exercise. We wonder why Dr. Jones has confined himself to the particular infections mentioned above, if he believes that such signs constitute evidence of hyperthyroidism.

How little is known about thyroid activity is well exemplified by the section on Tests for Thyroid Activity, which concludes with a statement that the only really reliable test is the estimation of the Basal Metabolic Rate.

Voices from the Past.

(*Continued.*)

The Senior House Surgeon.

The Senior House Surgeon had under his care the whole of the surgical wards, in the absence of the surgeons. It was to him the dressers appealed for help or advice during the greater part of the week. He had plenty to do in helping one body or the other. If a dresser had a fracture at the hip-joint to put up, and there was some difference of opinion among the small knot of dressers as to whether it was extra or intracapsular, it was to the H.S. they appealed. If it was a dislocation and there was disagreement as to the variety, it was to the H.S. they went as umpire. If anything of minor surgery had to be done in the surgical wards, it was the H.S. who did it. In this way I learned *how* to pass an O'Beirne's tube in fæcal impaction causing obstruction, a remedy that has on several occasions since been of great value to me.

If a serious accident, such as a depressed fracture of the skull, came in during the evening and neither the Surgeon nor Assistant Surgeon could be found, the H.S., according to rule "proceeded to do the necessary operation himself." The Senior Assistant Surgeon of my time was "courting" during my term of office, so rather luckily I had to do some major work I should not have had otherwise.

Amongst these was an amputation of the arm. My friend, who shared rooms with me when we were in lodgings, had an amputation of the thigh under similar conditions. In both these cases the surgeons in charge signified their approval afterwards.

When a fresh surgeon for the week came on duty, the H.S. used to ask him, "Up to what time do you wish to be sent for?" The older men would say, "Not at all; send for the Assistant Surgeon." Others would say, "Up to 10 or 11 o'clock; after that the Assistant Surgeon." There was another feature of the appointment. There was a certain amount of private practice to be done. When I was dresser the H.S. was called in by a G.P. to attend a carriage accident. Why they selected him I do not know, but he went many times. It was a compound fracture of the tibia and fibula. I went once for him and earned the first guinea of my life. When I was H.S. a youth, quite a stranger to me, asked me to take him in hand. He suffered from an acute specific urethritis. He soon got well, but paid a guinea each time he came.

I have now said enough to illustrate the duties of H.S. and dresser. They were both valuable appointments and said to be the best of the kind in London. Both H.S. and dresser were treated so handsomely by the Surgeons. No one but a sluggard could fail to be inspired by their encouraging kindness. Even at the College of Surgeons, when I was being examined on the base of the skull and could not recall a name, old Teddy Cock came up to me, put his hand on my shoulder, and patting me on the back said, "T-t-take your t-t-time now. I know you know it as well as I do."

Durham.

There were two classes of cases in which we had reason to think Durham considered himself specially skilful. The first was the operative area which included the nose, throat, palate, and larynx. When he had to do an operation on any of these parts, he brought down to the hospital his own special instruments. The next class embraced the perineum, uretha, bladder, etc. A good dresser who understood Durham soon learnt that he had also to understand his instruments. He liked in these "set" operations, when he held out his hand, to have the particular instrument he required. No word to be spoken, but for each step of the operation to follow quietly in order to the end.

On such an occasion he was about to perform a Cock's operation, one he loved to do and do well. I have assisted him at various times to do this. I stood close to his right elbow and held in my hand the knife, the long grooved probe and catheter, the tapes in my pocket. When the patient was in proper lithotomy

position, with shaved perineum and scrotum held back by another dresser, Durham sat on his stool, and, surveying the parts, passed his left forefinger well into the rectum, then bending his elbow, would twist his hand round like a policeman expecting a tip. Into this hand I would first place the knife; then, when the one deep, long incision had been completed, he would again turn round his hand, when I took away the knife and gave him the grooved director. When this had been passed and his finger removed from the rectum, taking hold of the probe in his left, he again passed his right hand to his back. Into this I would put the gum elastic, or rubber, catheter which he would pass and give it into my charge to tie in and apply suitable dressings. One might say it is "faddy," but this is how he liked to do it; silently, and divided into about four distinct movements or parts, it was completed in about as many seconds.

On one occasion he had to do this soon after the appointment of a new Assistant Surgeon. Though senior to me, he was a friend of mine; I had known him from my first entry into the hospital. Flushed with his success he came hurriedly into the theatre one afternoon just as Durham was about to begin his favourite operation. I stood at his elbow as usual, holding the few instruments in my hand; the new Assistant Surgeon bustled up and wedged his body between me and my surgeon. I gave place freely, so that I was pushed apparently quite out of touch. Presently the bent wrist and hand came round, but nothing was put into it. After a few moments Durham's astonished face turned to find the reason. Instead of seeing me he beheld only the newly-elected Assistant Surgeon. His face was a picture of blank surprise, as he cried in a high key, "Mr. Blank, you are standing in front of one of my dressers!" It was a most comical situation, for the tone of his voice indicated an unheard of piece of impudence. But with a giggle all round, the new dignitary apologised and skipped aside, and the operation proceeded as usual. The incident is trivial, but it shows the estimation in which Durham at any rate held his dressers.

On another occasion, in Accident Ward, he stopped as we were walking up the ward together to speak to an old lady. I passed on round the corner; when he came up again with me he said, "I wish you had stopped, that was Mrs. Gladstone; I would have introduced you." Miss Gladstone, I learnt, was acting as nurse in that ward, and her mother had called to see her.

"Apartments, etc.," Fifty Years Ago.

A suggestion has reached me that I should write on the subject of what may be called the "Students' Lodgings" in those days before the College was built. I am not conscious of anything different to the usual arrangements. Each man made his own taste his guide as far as his means allowed him, and these differed according to the work he was doing and the appointments he held at the hospital. The average allowance from home was about 35s. per week; this included no extras, such as season ticket, books, clothing and repairs, just for ordinary battels. If I may judge of present times by the condition of things now at our Universities, I should say that the sum mentioned would be an equivalent to-day of about £3 10s. Of course, I cannot tell accurately. For the usual sitting and bedroom one never paid more than 14s.; occasionally, in the suburbs, it was possible to get very comfortable quarters at 12s., but this was risky. In the sixties I had two most satisfactory rooms with attendance at 12s., but never afterwards One generally tried to find another friend to share the sitting room. This made a great difference, and if there was similarity in pursuits, taste and work it was an excellent arrangement, but if a man wanted to read hard he had to be sure that his companion was well chosen.

Towards the end of my time at Guy's a friend and I had the drawing-room in common as our sitting-room. The three rooms then came to about 24s.. Then the dining-room and another bedroom fell vacant, and we asked a third man to join us, which he was glad to do. We all knew each other very well, and were all together at our examinations and appointments. This amounted to 38s. or 40s., for we reserved the dining-room for meals and reading; no visitors were ever shown into the dining-room. After breakfast we left and did not re-appear till dinner at 5.30. The landlady was a very fair cook and clean, and, on the whole, this was the best and most comfortable lodgings any of us had, for it included much more cooking than was usual, as it was the only instance we knew of men dining at their lodgings. Dinner was generally taken elsewhere and cost from 1s. 6d. to 2s. and the tip 2d. But we all three found that we had more

spare money in our pockets at the end of the week than when we lived alone. Another thing, it got rid of our taking the heavy meal of the day at noon, or soon after, which always produced a feeling of more or less drowsiness. Anything more than the lightest lunch at 1 p.m. is contra-indicated if a man wants to keep his head clear and sharp during the afternoon. But with dinner in the evening after one has done a good day's work, a rest or nap is not only permissible, but essential, if one has to do another four or five hours' reading.

But dining out in the evening was rather a more extensive and expensive affair than most men cared for; so the rule of the majority was dinner at the "White Hart" or "Half Moon" at 1, and tea at 5 or 5.30 at their lodgings.

I have been told that *some* of the very hardest workers at Guy's, and men who have gained honours had an allowance only of £1 per week. If it is true, and I suppose it must be, I don't know how they did it. To begin with, they could only afford a single bed-sitting room and their food must have been only of the very simplest and plainest description.

Trinity Square and Merrick Square were the centre in and around which the most men lived, including Falmouth Road. In all these a man might be sure of being comfortable, as the landladies knew the habits of Guy's men pretty well. Here the charge was 14s. for rooms and attendance. Some few were 16s. For 14s. a man could get as comfortable rooms as he needed, where things were clean, the attendance good, and there were no children or other noisy lodgers to disturb his work.

When holding the appointment of "Extern" it was necessary to live close to the hospital if one wished to stand any chance of getting "cards." Some of the employés of the hospital lived in Maze Pond and let rooms for this purpose. They were willing to be disturbed at all hours of the night on consideration of a slightly extra charge. Of these the most popular was at the house of Ware, the p.-m. man. He was an excellent old man, a skilled sectionist of the cadaver, and had an ever-ready smile to oblige his tenants with in all their little fads. Did one want a brain hardened in spirit he would always provide it, or similar delicacy, and there was no objection made to keeping the glass jar in the sitting-room. If the loan of a skull, or carpus, were required from the hospital one had only to ask Ware. But the district was too full of houses and narrow streets to make his rooms desirable for permanent residence; besides the continual clatter of Ware's feet up and down stairs during the night made some people begin to talk of insomnia. The man, also, who assisted the Museum keeper lived close by. His, too, were excellent rooms at 14s. These were very good rooms if one was lucky enough to get them, for anyone holding an appointment. They were generally bespoken, for there a man was sure of cleanliness, good attendance, perfect quiet and civility and scrupulous honesty.

The best arrangement for a man to make was in his early years to lodge in one of the suburbs, such as Brixton, Clapham, New Cross, etc., where the air was less polluted. Then, when he began to hold appointments, to consider whether he had better not come up a little nearer. The expense was much the same, but the drawback to the suburbs in the eyes of some was the loneliness; the advantage to others was the isolation favourable to hard work. If a man got comfortable, congenial rooms in the suburbs he generally kept them so long as he could make arrangements for the vacations. Hard-reading men often kept up during these months, just running down home for a few days now and then. Most men, in for a pass only, liked to be near others where they could get a rubber occasionally. It was a matter of choice.

To sum up, a man could live on 30s. a week if he was careful, but all beyond 35s. was detrimental, as it was a temptation to theatres, leisure and frivolity. Rooms could be had for 12s. now and then, but 14s. was the usual weekly rent for comfortable apartments and attendance. When the College was first built it was considered that the expense came to rather more than it cost to live in rooms as described above.

I had once rather an adventure when living at the upper end of Falmouth Road. The pair of us had paid a visit, with a third, to another man living round the corner in Trinity Street. After our rubber, the three of us came out and found it raining. Quickly putting up our collars, we started to run to our own rooms close by. No sooner had we started than—bang! came something and sent two of us flying. We found ourselves lying in the mud right out in the horse road. I was the farthest

out, having received the primary impact; the other man came off rather less damaged. Picking ourselves up we sought the cause. It was a policeman who, being aware of the propinquity of a large criminal population, was standing caché in a protected niche of the house. We asked him what he did that for? Instead of the civil reply and apology we expected, he broke out into an angry exclamation of abuse. We asked him to apologise. He simply scorned to do any such thing. So I said, "Very well then, I shall take your number and report it at the station." At this he put his lamp into my face and said, "You'll take my number, will you? Here's a light, plenty of light, take it." We could not understand, but all four of us at once went to the police station in the Borough and saw the inspector on duty. He took down our words in writing and looked at our clothing. So fierce had been the impact with which I had been driven along the ground that the cloth had been scraped off the buttons of my coat, showing the bright metal surrounded by a border of rags. The coat was spoilt. The other man was only rolled in the mud, the third was not affected, as he was a few feet off when the "charge" was made. It was hard to understand as we were all footballers. I was a heavy-weight and not often off my feet. Here, I had not only been knocked down, but sent scraping along the ground. I could hardly believe it. The inspector looked very upset, he said but little, but pulled his moustache thoughtfully. Fortunately we had not had anything to drink, so there was no smell even in our breath. He asked very few questions, but looked puzzled and promised that the thing should be seen to. The next morning, as I was dressing, a message came that a gentleman wished to see us. I was deputed to interview our visitor, as we suspected who it was. It was a white-headed old gentleman in plain clothes, who had come to ask our intentions in the affair of the night before. I said that we had talked it over, and we wished only for an apology, if the constable were reprimanded, as we did not desire to take any steps that would injure his expectation or promotion. If he would apologise and say he regretted his insolence and would promise to try to do better in the future, that was all we wanted. The old man was thunderstruck; he could hardly believe his ears. At length he said, "Well, it is very good of you to say this, for it will make a great difference to him; for, I may tell you, that there was another exactly similar charge against him the same night, and the two together, if pressed, would be serious." "We shall be satisfied if he apologises," I said, "and I hope it will be a lesson to him." "You shall have that," he replied, earnestly, "and I think it is extremely kind of you." "By the way," I added, "he must be a powerful man, for, as you may see, I am not easily sent flying like that." "He is an exceedingly powerful man, as strong as a bull," he said. "I cannot think what he was about."

Later on the culprit called and made us a handsome apology, a thick-set, muscular young man, who looked quite another person to the brutal offender of the night previous. After a little fatherly advice had been given he went his way.

Soon after this event, we three came on duty, one after the other, as H.S. I was second in order, the third was the one of our party who had not been struck. When I took on the office of H.S., my predecessor (our host on the memorable evening) said that there was a very bad case of tubercle in the wards, a skeleton almost, tubercle everywhere, lungs and all. "It is the brother of our stalwart policeman, and he comes to see him frequently." It was so. As the burly brother sat, he often looked as though he would like to say something about past events, but we made it a point to say very little about anything, and nothing at all about outside matters. But we were particular to see that his brother had every attention, and was in no way neglected. They formed a great contrast, the young, great muscular giant and the dying skeleton.

We had no information on the subject, but there was every reason to believe that the other person assaulted that night had also been satisfied with an apology, for the constable was evidently now making headway and profiting by the lesson he had learnt.

Labuntur anni. I am now the only one of that group left. Of the four of us concerned in the adventure, one, on inheriting wealth, forsook his profession, took to the turf, and died in the lunatic asylum. Another forgetting for the moment that he, too, was a victim of mitral disease, which carried off every one of his brothers and sisters, and was beginning to grip him also more and more tightly, ran a few yards to catch a train and died in the carriage. He was returning from taking his only son to school.

The other, heroically fighting the plague as physician to the Jamsetjee Jeebehow Hospital, in India, was unfortunate enough to die from the disease himself. I, alone, am left to fulfil my detiny, and watch other shadows as they, one by one, showly fade into the boundless deep of the unknown, whence they first came.

(To be continued).

Rugby.

GUY'S v. OLD LEYSIANS.

This match, played at Honor Oak Park on Saturday, September 30th, ended in a big score for the Hospital, 8 goals 5 tries, 55 point, to nil, and all in two 30-minutes represents very fast scoring.

The Hospital side was in very fine form, and it is doubtful if even a stronger side than the Old Boys could have withstood to a much greater extent the varied, speedy and bewildering attack of the whole fifteen that represented the Hospital. Five of the tries came from the forwards; they were always well up and ever on the ball. The first try was really set going by Taylor and finished beautifully by Albertijn with just that touch of cleverness that means success. Taylor next scored himself, and then by a dribble in which the Cornish Captain and Neser were prominent, Duncan came along at the right moment and scored a try. Steyn was the next try getter, and then Albertijn threw a wide pass out to Steyn who gathered at full speed and romped over, giving his opponents a fine view of his heels. Hutchinson, who appears to have gained pace, finished a run with a score which Van Schalkwijk converted, as he had done the three previous tries.

The second half was still very much in our favour; the Old Boys became weaker in the tackle, and Guy's fairly ran them off their legs. The game had been carried on at a tremendous pace, and this never slackened till the final whistle.

Just previous to the interval Bekker and Harvey gained tries, and the string of tries was further added to, this latter portion of the game, by four tries from Sprong and one each from Holloway and Steyn. Two of Sprong's tries in particular were very clever, and all through the game he displayed his versatility and elusiveness. Bekker was not much troubled by his opposing half, and with the forwards holding throughout the upper hand, he had quite an easy day. The whole side played exceedingly well. It would not be fair to mention individuals except to say that the re-appearance of Duncan was both welcome and popular. The back division was exceedingly good, both centres masterly, and Badenhorst improves game by game. Guy's 8 goals 5 tries (55 points), Old Leysians nil.

Guy's Team.—W. Badenhurst, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, G. R. Mostert, F. Bekker, E. L. Sprong, R. F. H. Duncan, W. H. Taylor, F. J. Biddle, E. E. Neser, P. G. Harvey, G. Zondagh, F. G. Hutchinson, N. M. Holloway.

GUY'S v. UNITED SERVICES.

A splendid afternoon it was on October 7th, a record attendance, and a great game at Honor Oak Park; hard, fast and clean was the play, and the vast number of spectators present cheered impartially the fine play of either side. Both teams were almost fully representative. Guy's missed W. D. Doherty who hopes to play very shortly.

The forwards of the Services started off with their accustomed dash. Guy's withstood this onslaught successfully, and the forwards began to settle down to their work, but the ball was not allowed much air and the quick breaking up for a time spoilt any concerted attack by either quartette. Rather did the game show signs of a kicking-for-touch contest. Bekker proved himself able to cope with the International Kershaw. Davies, the English Captain, found touch with many fine kicks, but in this respect Van Schalkwijk was as usual unerring. Sprong was inclined to do much on his own, but he was not quite at his best. Versatility is a great thing and Sprong does well to vary his game and not always give the orthodox pass to his centres. Albertijn sent Mostert over for the first try after the game had been in progress about 25 minutes. Neser, with a fine kick almost from the touch line, just missed the extra points. Before half-time Hutchinson scored from a line out; Badenhorst magnificently converted, and ends were changed.

Our forwards had now thoroughly found themselves, Taylor, the best of both packs; Neser, splendid in all departments; the others, with Scholefield probably the pick, doing their own job well, Biddle shoving hard, Zondagh in the thick of everything. Duncan unfortunately was crocked twice. Holloway showed by his energy to the very end what fitness will do. Still from a line out Rayner, of the Services, got away and scored an unconverted try. Now came a well earned try and conversion by Van Schalkwijk; backing up some good work by Albertijn, who ran on to get a try favourably placed. Again both sides went at it; the pace was terrific, and it was gratifying to notice the Hospital men lasted the better. We frequently got the ball, but seldom did it reach Mostert and scarcely ever Steyn. Before the end Bekker got an unconverted try. Davies was too well watched ever to do much but kick. The line behind him was never very dangerous, and Stephenson, the Irish "Cap," got little opportunity. A game so keen, with

the men on the ball all the time presents few chances to the side that is mastered in the tight. Guy's won by 2 goals 2 tries (16 points) to 1 try (3 points). It was a hard-won victory, but it was also well deserved. A contemporary says, "Guy's will probably improve." GAZETTE readers may take comfort from those four words. One scarcely doubts the statement, and the fact anyhow remains that the Hospital team promises to rival, if not to excel, any of its great predecessors.

Guy's Team.—W. Badenhorst, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, G. R. Mostert, F. Bekker, E. L. Sprong, R. F. H. Duncan, W. H. Taylor, E. E. Neser, B. G. Scholefield, G. Zondagh, F. J. Biddle, F. G. Hutchinson, N. M. Holloway.

GUY'S v. BIRKENHEAD PARK.

Considering that the Park team had been at Blackheath on the previous Saturday, quite a good crowd assembled at Honor Oak Park on Monday, October 9th, to witness the above fixture. This is the first time the crack Northern team had been to the Hospital ground. They provided a splendid game, being fast and fit; H. M. Locke in the centre was a host in himself. Albertijn was away on holiday, also Mostert; and Duncan, badly crocked on the previous Saturday, will, one regrets to state, have to rest for some weeks. A great asset to the Hospital was the re-appearance of W. D. Doherty, and the three-quarter line was reconstructed, Fellowes-Smith coming in on the left wing, Steyn going to centre and A. Hirschberg playing on the right wing. Both these men—Fellowes-Smith and Hirschberg—played well and did all that was possible. One can congratulate the Hospital on having such excellent reserves.

The play was exceedingly keen and our visitors set about their work with tremendous *élan*. There was no quarter given or asked, and the tackling was thorough. Rather a lot of touch-finding was evident at first. Some exceedingly lengthy kicks by Pemberton drove our forwards back, but not for long. Doherty led the Hospital pack again and the ball was well heeled, but Sprong appeared to distrust the line behind him. An excellent movement by Van Schalkwijk was unlucky not to score, as he kicked cleverly ahead, for Hirschberg to dash up, but the ball just found touch. Then a penalty was awarded us for Neser to goal from a difficult position. Undismayed, the Park drove us to midfield. A cross kick dropped for Locke, coming on at full speed with rare vim, to kick on, gather, and score. No goal resulted. Fellowes-Smith got a good try just after; he eluded Craigmile, the old Cambridge Blue, but the place was wide and the kick at goal failed.

The second half was even more interesting than the first, the forwards showing up and breaking away very quickly. Bekker did some very good spoiling at the scrum base; he dropped on the ball or picked it from the feet of the Park men with great daring. Then came some passing by our men; Fellowes-Smith was almost clear and Scholefield was tackled inches out. Just now Taylor was superb; he followed the ball with uncanny persistence. Holloway, Neser and Hutchinson one must commend. From nearly half-way Neser had another shot from a penalty, and successfully steered the ball between the uprights. Locke was showing signs of damage; still the Park forwards carried on the grim struggle, but their backs did not do much in attack, and soon a hot attack by the Hospital three's was set up. Foiled on the left, and breaking down through a slip up in front of goal, Steyn took a long pass and swung out to Hirschberg, who got right round to place beneath the bar. Van Schalkwijk unaccountably missed the goal. Guy's won by 2 penalty goals 2 tries (12 points) to 1 try (3 points). It was a fine game. S. H. Daneel shaped very well, and he had at first plenty to do. The whole team played well. They were together, well led and eager, and the absent captain will enjoy his holiday all the more when he hears of this victory.

Guy's Team.—S. H. Daneel, A. Hirschberg, C. L. Steyn, J. G. Van Schalkwijk, R. Fellowes-Smith, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, E. E. Neser, G. Zondagh, F. J. Biddle, B. G. Scholefield, F. G. Hutchinson, N. M. Holloway.

Fencing.

[Oxford University are probable opponents for next season, as are also the H.A.C., R.M.C. Woolwich, R.A.F., Cambridge University, *Gracie's Academy*, and other Hospitals.—*Vide* Guy's GAZETTE, September 30th, 1922, page 400.]

I.

Every Gracie I have known
Hitherto has been so tender,
That I instantly have shown
Symptoms of complete surrender;
And, the dandiest of the dandies,
Wooed her with a box of candies.

II.

Gazing, calf-like, in her eyes,
Pouring forth impassioned speeches,
I would mingle with my sighs
All the arts that practice teaches,
Till her little heart I'd spear
Through my Gracie's middle ear.

III.

Those old methods now are vain
To achieve love's latest task.
Idle words will never gain
Gracie of the iron mask.
So—I'll lightly run my sword
Through the heart of my adored.

IV.

No more peppermints and kisses.
Love would now be with a snub met.
So my fiery rapier hisses,
Pinking holes in Gracie's doublet;
Till I reach that heart of Gracie's
Through her intercostal spaces.

Cricket Report, 1922.

On looking through the records of last season, we find it quite unaccountable that a team, while commencing so consistently well, should have become so mediocre after the first few matches. There is no doubt that fundamentally the team was strong; unfortunately its true form was rarely shown. With, perhaps, the exception of three occasions, the fielding was undoubtedly poor, and the bowling, although good in a few matches, was certainly not what it should have been; the same may be said of the batting.

The season might have been much worse, and our woeful comments have only been given in an endeavour to explain away the lack of success which attended us during the latter part of it, despite the talent we had at our disposal.

Wooldridge is to be complimented, not only on keeping up a fine all-round standard, but also on setting a splendid example in the field, which it is a pity some of us did not follow more ardently. Arkles and Van Schalkwijk especially were keen in the field, and they, with Williams, revealed batting abilities which promise well for next year. Helder made a lot of runs, but his batting lacks polish, while Shearer has certainly improved. Biddle bowled his "leg breaks" with very encouraging results, and made runs on occasion. Usually Van Schalkwijk bowled well, and sometimes he was very difficult. Unfortunately we had no regular wicket-keeper.

RESULTS OF MATCHES.

Date.		Club.	Gnd.	For.	Against.	
May 6	S	Bromley	A	*210 (3)	176	W
10	W	Catford Wanderers	H	81	59	W
13	S	Sevenoaks	A	*233 (4)	99	W
20	S	Honor Oak... ...	H	94	96	L
24	W	Hampstead ...	A	207 (8)	*251 (6)	D
27	S	Three Counties ...	A	195	125	W
June 3	S	L.C.W. & P. Bank...	A	*140 (6)	115	W
7	W	Downing College ...	A	213	214 (9)	L
10	S	Cyphers	H	147 (9)	261 (5)	D
13	Tu.	King's	H	*317 (9)	108	W
17	S	Old Charlton ...	H	*211 (4)	158 (3)	D
21	W	B.N.C.	A	143	144 (6)	L
24	S	Bromley	H	17 (0)	*215 (8)	D
28	W	Streatham	A	112 (3)	—	D
30	Fr.	St. Thomas's ...	H	140	217 (4)	L
July 1	S	Cuaco	H	*237 (6)	187 (9)	D
5	W	Gravesend	A	54 (1)	*204 (4)	D
8	S	Past...	H	136	115	W
15	S	Honor Oak... ...	A	79 (6)	*257 (5)	D
25	Tu.	Thespids	H	159	74	W
Aug. 5	S	Cane Hill	A	111	199	L

Played 21. Won 8. Lost 5. Drawn 8.

*Declared. Cup Tie underlined.

BOWLING.

Name.	Overs.	Mdns.	Runs.	Wkts.	Ave.
F. J. Biddle ...	92	7	406	38	10·68
J. G. Van Schalkwijk	187	35	637	37	17·22
T. Wooldridge ...	205	39	656	36	18·22
L. S. Williams ...	41	4	174	8	21·75
N. H. Saint ...	69	12	205	7	27·86
G. D. Shaw ...	106	15	397	14	28·36

BATTING.

Name.	Inngs.	Times not out.	Runs.	Most in Inngs.	Ave
T. Wooldridge ...	19	7	814	152*	67·83
L. B. Helder ...	16	3	406	100	32·00
L. S. Williams ...	11	1	338	111	30·73
C. Arkles	8	3	167	60*	20·87
N. H. Saint... ...	8	3	159	32	19·87
J. G. Van Schalkwijk	11	3	191	58*	17·36
F. J. Biddle ...	6	2	104	45	17·33
G. L. Shearer ...	9	2	140	40	15·55
G. D. Shaw	14	0	167	45	13·36
R. F. H. Duncan ...	5	0	55	27	11·00
A. G. Ensor ...	10	2	77	13	7·70

*Not out.

Shirley Park Golf Club.

Played at Shirley Park, Sept. 17th, 1922.

SHIRLEY PARK G.C. v. GUY'S HOSPITAL GOLFING SOCIETY.

Shirley Park.		Guy's Hospital.	
R. G. Richardson (Capt.)	0	L. Bromley	1
G. Fowle Evans ...	1	L. W. Cann (Capt.) ..	0
T. H. Hartog	1	K. Hooper	0
O. R. Schuberth ...	1	F. E. Graham-Bonnalie	0
H. A. Harrison ...	1	F. James	0
A. C. Yates	1	G. D. Shaw	0
H. E, Camidge ...	1	T. A. Shaw	0
G. Hoyland	0	H. Moore	1
	6		2

Shirley Park, 6. Guy's Hospital, 2.

Swimming Club.

The following have been recommended for the award of Half-Blues for the Season 1922:—

Water Polo.—John Simons.

Swimming.—H. Richards.

Marriage.

GOBLE—HEWLETT.—On the 21st September, 1922, at St. Matthews, Bayswater, W., by the Rev. N. Rostron, Surgeon Commander F. G. Goble, Royal Navy, to Ivy Marian, younger daughter of Paymaster Captain Graham Hewlett, C.B., Royal Navy (retired) and Mrs. Hewlett, of 10, Strada Mezzode, Valetta, Malta.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE believe that the letter which we publish on page 443, dealing with the present overcrowding in the wards, voices an opinion which is shared by many at this Hospital. But we do not think that concurrence with the writer's views on the part of at least a section of the Hospital community, may be taken as evidence in support of their accuracy. Our correspondent is of opinion, justly enough, that the value of clinical appointments is lowered to a very large extent by overcrowding, and that any measures which tend to perpetuate the abnormally large number of admissions to the School are to be deprecated. With this we agree. But when he assumes that no remedies are being applied, and no measures being taken to prevent overcrowding in the future, we cannot but infer that he is writing without full knowledge of the facts of the case.

It is true that after the war, especially in October, 1919, the number of Students who entered the Hospital rose to a height far above the normal. This great influx of Students balanced the very low number of entries during the war years, and was, we believe, due to a desire to accommodate ex-service men who wished to take up medicine as a profession, or to resume their studies after the war.

But, as matters stand at present, the general aspect of affairs has changed considerably. The names of those wishing to enter the Hospital are now, and have been for some time, submitted to a Selection Committee, with the result that although many have been called, not all have been chosen, and the number of entries has been reduced almost to normal.

We can assure our correspondent that the reforms which he urges are already in force.

Of course it must also be remembered that the number of those who apply for admission to the Medical School has fallen considerably in recent months.

A DINNER, attended by many distinguished physiologists, was held recently by the Physiological Society in the College smoking room. Various discussions took place, and papers were read. The discussion in which Professor Pembrey and Dr. Flack took part is of especial interest to Guy's men. Professor Pembrey opposed the view that certain special tests of physical efficiency, applied to members of the Air Force, could be regarded as adequate evidence as to their ability to perform their duties. As

a result of work done recently at Guy's, it has been shown that many of our best athletes, including members of the Rugby team, may be less successful in the performance of these tests than men who are not so highly endowed as regards physique and stamina.

It would seem that it is impossible to decide absolutely, in the absence of organic disease, upon the fitness of a person for any form of physical exercise, by any test but the performance of the exercise in question.

The matron has given permission to nurses who wish to be present to attend the meeting of the Physical Society on November 9th. At this meeting, which will be held in the anatomical theatre, Dr. Leeson will read a paper on "Some Personal Memories of Lord Lister." Dr. Leeson was one of Lord Lister's house-surgeons, and his reminiscences will be of the greatest interest to all medical students. The meeting should be well attended.

We are glad to hear that the nurses will be allowed to be present.

THE account of Sir Charters Symonds' inaugural address to the Physical Society, which we are unfortunately not able to publish to-day, will appear in our next issue.

WE are asked by the Secretaries of the Football Clubs to announce that, in future, teas will not be provided for members of the Clubs' Union upon Match days at Honor Oak Park, unless they are in possession of tea tickets which will be issued by the groundsman before the match.

There is usually so large a crowd of people demanding tea on these occasions that their requirements cannot be met. It has, therefore, been decided to supply tea only to those who produce tickets.

The number of tickets is necessarily limited.

ABOUT a year ago these columns contained a complaint as to the state of the roads around Maze Pond. Much sympathy was expressed for the externs, whose sufferings while jolting along upon the bad patches which distinguished all the thoroughfares around the College at that time were dwelt upon with considerable feeling.

It is encouraging to note that our recommendations have been adopted, and that the roads in the neighbourhood are now under repair. We may say without undue self-inflation, that this is not the first time the GAZETTE has been able to demonstrate the Power of the Press.

AT this season of the year we are once more reminded, by the early "Nigger" practices, of Christmas festivities. The Residents are even now beginning to choose their songs for the performances, and the first practice of the troupe has already taken place.

We should like to see another Residents' Play this year. So far we have not heard that any new playwright has arisen, but we hope that, whoever he is, a new Brookhouse will soon get busy.

There should be no lack of talent in the Hospital at present.

We have received numerous enquiries from those who are anxious to know what reasons a member of the Surgical Staff had for wishing to break into the Medical Report Room at a late hour last Saturday.

Appointment.

C. S. Lane Roberts, M.S., F.R.C.S., appointed Demonstrator of Midwifery, St. Bartholomew's Hospital.

League of Nations and the O.T.C.

Gen. Smuts replies to an interesting question.

In a recent number of the "Sphinx," the organ of the Liverpool University students, there has been some discussion of the question whether membership of an O.T.C. is compatible with whole-hearted advocacy of the ideals and proposals of the League of Nations. It was agreed to submit the matter to General Smuts for his opinion, and his reply is given in the number of the "Sphinx" issued yesterday. It is as follows:

"I have read the correspondence in reference to the question which has arisen at Liverpool University, namely. Whether a student who believes in the peaceful ideals of the League of Nations should join the O.T.C. For myself, personally, I have no difficulty in answering that question. If I had the good luck to begin my University career as a young man to-day I would not hesitate to join both organisations. That would be in the spirit of Cromwell's advice: Trust in God and keep your powder dry. I do not see why the two should clash. Ordinary citizen military training, such as has existed for a hundred years and more in Switzerland, does not constitute militarism, and is perfectly compatible with the new ideals of peace for which the League stands. The student who joins the O.T.C. does not join a military caste, but is simply trained to defend his Country and his ideals in case of an attack. The League does not guarantee us against all wars, and, therefore, our duty to be ready to defend our Country in the last resort remains. That is how the case presents itself to my plain common-sense."

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Congestion in Ward Appointments.

SIR,—In connection with the great congestion which is so evident in all the ward appointments, from Surgical Ward Clerk onwards, are the authorities quite satisfied that they are justified in admitting new students in large numbers?

With the present number on a firm it is almost impossible for more than a minority to examine a case under discussion or even to see it.

Surely this policy is harmful to the reputation of Guy's as *the* Hospital above all others which offers practical experience as opposed to lectures and book knowledge.

Moreover, one would ask is it fair that the new student, who comes to Guy's with this reputation as one of the chief motives of his choice of hospital, should find that he is no better off than at many overcrowded hospitals which are notorious for the lack of opportunity for practical experience.—Yours faithfully, M.

Guy's Hospital, S.E.1.

Medical Education.

SIR,—I know that I have read "E's" letter, and only hope I have understood what he means.

I must confess my full agreement with his plea for an education in science; I maintain an equally adequate disagreement with his implicit suggestion that the present preliminary science system deserves perpetuation as such an education.

The hurried memorising of a considerable number of chemical and botanical facts, insisted on by all examining boards, and connived at by the G.M.C., is, in my opinion, the policy least calculated to lead to the goal he so eloquently advocates.

May I suggest that the essence of a scientific education is learning rather than being taught? Is not the best place for the former, admittedly the slower process, in the wards of the training hospital and in the years of the budding medico's less complete immaturity.

Perhaps I wander from the original subject if I express the opinion that the present method of staffing a teaching hospital tends to bring students under the influence of men successful rather in the art of practising medicine than necessarily distinguished in medicine as a science.

May I, in conclusion, congratulate E. on his passion for the periodic classification, and express my hope that some students under the present regime really know what it means?—Yours faithfully, TUTUS.

October 12th, 1922.

Bread-Casting.

SIR,—May I, through your columns, voice a protest against the abominable behaviour of the residents at dinner every evening in the college dining room? I should hate to suggest that any traditional practice at Guy's be abolished, but this childish exhibition of bread throwing has been but recently started and is probably encouraged by an occasional sickly grin from the audience. We have now to swallow our stale meats to the accompaniment of a demoniacal orgy of plate smashing and table turning. The Residents are, quite rightly, privileged people

and deserve their nightly amusement, but I feel sure the majority of others who live at the College would be quite willing to subscribe towards the construction of a sound-proof dining-strong-room, where they could nightly hold wassail, and dinner still remain for us a pleasant hour.—Yours etc.,

AD NAUSEAM.

P.S.—The bread wasted by the Residents might be converted to a much more worthy use as poultices for the Front Surgery.

Pass List.

L.D.S.

FIRST EXAMINATION. SEPTEMBER, 1922.

Part I. and II.—*Dental Metallurgy and Mechanical Dentistry.*

E. J. Andreka.
†R. A. Winnett.
*I. A. Barlow.
R. Bliden.
W. G. Bradbeer.
A. T. Brimmer.
M. L. Cooper.
E. J. B. Curtis.
*D. Davies.
P. Droomer.
J. J. du Toit.
R. R. Haddow.
G. G. Exner.
†T. S. Davidson.
†D. A. James.
†A. C. Luck.
†E. H. Sears.
*H. E. Spencer-Payne.
E. F. Farmer.
J. W. Finnemore.
S. W. Goodson.
E. C. Grant.
R. M. Harford.
†E. M. Harries.
A. C. Kempe.
†H. C. Lawrence.
†W. H. C. Lean.
F. T. Lowein.
†W. H. Meissner.
J. G. Nelson.
K. F. Pedley.
†A. C. Evans.
†H. D. Kendrick.
†E. C. Woodhead.
†F. L. O. Seymour.
H. M. Pimm.
H. H. Revill.
D. M. Timpson.
W. F. C. Tusker.
†W. de Worster.
*L. Walters.
*G. V. L. Williams.
*N. J. Boulton.
*R. C. Broadbridge.
*G. W. Dibble.
*G. W. Gatergood.
*G. L. Gould.
*W. L. Head.
†W. Foster.
†G. N. Lewin.
†F. N. L. Price.
†G. G. Tregarthen.
*W. E. Herbert.
*A. Hirschberg.
*H. B. Kidner.
*I. Lepschitz.
*V. W. Percival.
*G. F. Swales.
*I. Thomson.
*S. E. Elkington.
†H. F. Boosey.
†R. V. Bradlaw.
†H. G. Brooks.
†H. B. M. Cahill.
†H. J. Daneel.
†N. Harris.
†G. B. Longhurst.
†F. W. Sander.
*L. H. Jones.

†Dental Metallurgy only.
*Mechanical Dentistry only.

Part III.

(A) *Anatomy and Physiology.*

J. R. A. Moore.
V. C. Warr.
R. C. Ballard.
A. Tuback.
L. S. Carter.
V. R. Estment.
A. D. Miller.
L. Nurick.
R. Hofmeyer.
T. S. L. Barritt.
A. R. H. Bennett.
W. O. Cooksey.
E. H. Fouraker.
E. V. Potts.
L. H. Jones.
J. F. Reynolds.
T. B. Berry.
I. G. Coutts.
W. V. A. Hodges.
E. Z. C. Pearson.
H. S. Spencer-Payne.
N. H. Saint.
W. E. Brigham.
A. A. Danino.
C. D. Lingwood.
L. C. Willis.
H. R. Allen.
S. S. Sanderson.
W. S. Brittan.
A. H. M. Dyke.
H. Metheringham.

Part III.

(B) *Dental Anatomy and Physiology.*

E. V. Potts.
E. Z. L. Pearson.
N. H. Saint.
H. M. Doubleday.
H. C. Warr.
T. R. Berry.
I. G. Coutts.
C. D. Lingwood.
W. L. Boness.
J. B. Maree.
A. S. Davies.
A. W. Reynolds.
R. Hofmeyer.
W. E. Bingham.
V. R. Estment.
W. F. Howe.
J. E. Lloyd.
W. Orsmond.
G. R. M. Van der Merwe.
L. H. Jones.
W. S. Brittan.
E. H. Fouraker.
E. G. Smallbone.
R. A. Tran.
G. S. Sanderson.
L. C. Willis.
T. S. L. Barritt.
W. O. Cooksey.
W. V. A. Hodges.

Change of Address.

Professor C. S. Gibson, 14, St. Thomas' Street, London, S.E.1.

Dr. H. A. Latimer, 8, Grove Hill, Tunbridge Wells.

Dr Allen C. Hancock, M.C., Bexley Mental Hospital, Bexley, Kent.

Correction.

We much regret that in our last issue it was erroneously stated that W. E. Tanner, M.S., F.R.C.S., had changed his address. There has been no change and we apologise for any inconvenience the announcement may have caused.

Myasthenia Gravis.

CLINICAL LECTURE BY DR. C. P. SYMONDS.

GENTLEMEN,—The disease which I have chosen for my lecture is a rare one—yet not so rare but that some of you are likely from time to time to meet with examples of it in your own practice. Two cases of myasthenia gravis have been admitted to the Hospital during the past three months; one, a man, has since died, and I shall be able to show you what we found at the post-mortem. The other is still alive and I shall be able to demonstrate to you this afternoon the nature of her symptoms.

I shall begin by giving you the story of her case, and if I go into great detail in the history of her symptoms, I do so with a purpose. Myasthenia gravis is a disease, which as you will see from the history I am going to relate, presents great difficulties in the way of accurate diagnosis, yet the correct diagnosis may be made as a rule even in the early stages by means of an exact analysis of the history of the illness. This patient, moreover, is a careful observer and her powers of description are adequate to the need of relating details of various rather obscure symptoms.

CASE I.

A. S., an unmarried woman of 44, a school teacher, in February, 1901, at the age of 21, was first taken to an eye specialist for drooping of the eyelids, which occurred especially when she was tired. She was told to wear glasses, but this trouble persisted off and on, and in 1908 she saw another specialist for the same complaint. She found it occurred particularly when she was tired, under a bright light, or when she was studying something difficult, *e.g.*, when trying to learn Greek.

On April 10th, 1919, she was in the best of health, and at the end of an hour's lesson, during which she had been talking most of the time, she began to read to her class a story. She then noticed that her voice was giving out. It first became nasal, just as if, she says, she "had a cleft palate." (She had a child with cleft palate in her class to whose voice she was accustomed.) She rested for a few minutes and was then able to read normally for a few sentences. The disability, however, then returned, and eventually, finding that the condition recurred, she had to give up her reading. She put it down at the time to a cold in the head, because she noticed she had a feeling which she describes as of perpetual mucus at the back of the nose. She wanted to clear her throat and the back of the nose, but could not do so.

Subsequently the trouble improved a little, but she found herself only able to talk for a little while at a time. At school she managed to get over this difficulty by writing many of her instructions on the blackboard. At home she became somewhat shy of talking with strangers on account to her disability.

As her voice failed, gutturals became impossible, dentals very difficult, and the ü sound also very difficult. Her lips would not come together properly. She found, too, that she could not whistle, nor blow a whistle, and she lost the power of suction. She discovered this last when sucking a piece of toffee, and subsequently experimented with her finger, being an observant person and interested in her symptoms.

She discovered also some weakness of her tongue, in that, when trying to clean her cheeks and teeth after a meal, this organ soon became so tired that it would not go round at all.

When she tried to sing, her voice, instead of striking against the palate and coming back, seemed to go right up into her head. She could start off a verse of a hymn well enough, but could not sing it right through on account of this disability. She also found that the pitch of her voice had descended in the scale: low notes were now much easier to compass than high ones.

All these symptoms tended, on the whole, to progress during the April to June of 1919, and at the end of the latter month she first noticed that the trouble had affected her limbs. She was doing physical exercises with her class, and having jumped over a rope and bent her knees to take the shock of coming down, her power of extension at the knee joint failed her and she fell forwards upon her face.

A few weeks later she went away on a holiday to Scotland where the weather was very cold. There the difficulty in speech increased rather suddenly; She was saying to a child, "Don't chew chocolate," when the sentence degenerated into a mumble and she felt as if her jaw were stuck. She imagined for the moment that she might have lockjaw; but when one goes into the story it is quite clear that the disability was weakness, not a spasm of the jaw muscles. This was illustrated also in the difficulty which she subsequently had in chewing. If she tried to eat an apple or a tough bit of toffee, after a while she would be unable to go on.

The weakness of her lips and tongue also increased. Towards the end of a meal the food would tend to drop out of her mouth, and she would have to hold her lips together with her fingers to keep it in.

The next trouble was difficulty in swallowing. She first discovered this after taking a pill, which she

found a quarter of an hour later at the back of her nose.

There appears at this time also to have been some anæsthesia of the pharynx, for one day a fish bone having stuck in her throat, she retired in order to dislodge it, and discovered that she could thrust her finger far back into her throat without producing any uncomfortable sensation—this to her great surprise as she had always before considered herself extremely sensitive in this part. The difficulty in swallowing during the subsequent week became worse; she had to take three gulps to one swallow; small particles of food she could not swallow at all—she says it had to be a fairly large piece to go down. Fluids were a very great difficulty, instead of going down they went up and came back through the nose.

At the end of this week for the first time she had double vision. She was on the top of a tram, when she says her right eye "seemed to swing out"—she saw four sets of tram lines instead of two, and in place of a tram which was coming in the opposite direction she saw two, one of which appeared to be running straight into that upon which she was a passenger, so that she was in instant fear of a collision.

She then consulted her doctor, came to London and saw an eye specialist, who examined the ocular condition carefully and was much puzzled. He eventually, in 1921, performed an operation shortening the tendon of the right internal rectus, but, as you will imagine, this did not improve matters.

At the same time she saw an ear, nose, and throat surgeon for her difficulty in swallowing. By the time she consulted him, however, the disability had completely disappeared and he was able to find no evidence of deranged function.

She then continued her holiday. The double vision was still present when she was tired, but otherwise she felt perfectly well.

Now, however, for the first time she began to notice loss of power in her fingers. After the first effort there was no pinch in them. She could do up her buttons only with great difficulty towards the end of dressing, and had to get someone else to fasten her suspender clip which required a powerful nip. She also noticed difficulty in doing her hair at this time. She found that while she was brushing up the back of her hair, her arms would gradually fall exhausted to her sides, and she would have to accomplish this performance by means of frequent rests. She got over this difficulty by sitting close up to a chest of drawers and resting her elbows upon it, or by sitting back in a low chair and bending her head backwards to meet her hands.

Then the trouble returned in her lower limbs. The country in which she was staying was hilly, and she began to find the greatest difficulty in walking downhill. One day in walking down a road she stumbled a little, her knees bent, and she fell to the ground without, however, hurting herself severely. She then found that she could not get up without the assistance of a passer-by.

In the following month, September, 1919, she returned to her work as a school teacher, and, except for the ordinary holiday, has been continuing at it ever since.

All the symptoms which I have already related are present from time to time in some degree, although none of them have been so severe as they were in the summer of 1919. This, however, she attributes to the fact that she takes good care to avoid prolonged employment of any particular set of muscles.

In getting about the streets she has trouble in boarding buses.

She has had, however, to give up singing, and to give up playing the piano, of which she was very fond.

At the end of a day she cannot rise from the kneeling posture without pulling herself up by a support.

After she has been sitting in a low chair she may find it impossible to get on to her legs.

She cannot lift a child in the ordinary way, although she manages to do so with the arms rigidly extended and the hands interlocked.

In washing her face with the sponge she cannot get enough pressure with one hand, but has to use both.

She is quite sure that her eyes droop more if she is facing a bright light. At times this has been so bad that she has had to hold her head back in order to see.

As I have already related, the degree of fatigability and the groups of muscles thereby affected vary from time to time, but she thinks that she is worse if anything during the week after the period, and she has noticed for the last four months that she has been definitely better during the period itself.

During the past year the symptoms were worst just before her summer holidays. Her lower limbs were so bad at that time that she could hardly walk at all, and could not get up even a small step without assistance. She describes herself as "feeling just as if I had got up after a bad attack of influenza."

You will have noticed in the story of this illness one constant feature—and that is an incapacity on the part of the voluntary motor system for sustained effort. If she has on occasions persisted in making a particular effort there has often resulted a temporary paralysis of the muscles involved. Power has always returned to some degree after a brief rest.

Various functions of the motor system have been involved from time to time, and there have been marked fluctuations in the course of the illness.

Thus we have, first, her story of undue fatigue of the palate, which she has so graphically described, and with this almost at once was associated fatigability of her lip muscles and of the tongue.

The alteration in the pitch of her voice—a lowering in the scale—probably means that her laryngeal muscles were unduly fatigable.

Then comes the difficulty in swallowing due to the fatigability of her pharyngeal muscles, and perhaps most characteristic of all the abnormal weakness of the jaw muscles which developed after much chewing.

She is a person of great common sense: she had at the onset of her symptoms consulted a doctor about her voice and had been assured that nothing serious was wrong, and therefore she did not worry further about this. But with the onset of double vision she was naturally alarmed. After her rest in bed, however, there was considerable improvement. From her account is appears to have been the right internal rectus which was first affected of the ocular muscles, although when we go more carefully into her history we find that she had suffered already for some years from drooping of the upper eyelids when fatigued.

Next the lower limbs are affected, while the difficulty in swallowing clears up so that by the time she is examined by a throat specialist there is nothing abnormal to be noticed.

Then the upper limbs are affected, and then appears a symptom which has been constantly present in the three women I have seen suffering from this disease—that is undue tiring of those muscles which support the arms while the patient is doing her hair. This I am told is always a fatiguing operation, and the symptom occurring in women illustrates, I think, a feature of the disease, namely, that the incapacity for sustained exertion is, as far as the limbs are concerned, first manifest in those muscles which are in the daily routine of life most constantly called upon. This in a man especially will vary with his occupation, and it has been argued upon this basis that undue strain upon a particular group of muscles may be a factor in causing the disease. But this, I think, is a fallacy.

Since this patient was admitted a week ago she has been resting in bed, and she states that she is comparatively free from symptoms. I can, however, demonstrate to you one or two points.

At rest, as you see, there is a little drooping of both upper eyelids—the left being rather lower than the right. But when I get her to fix her gaze upon an object which demands extreme upward deviation of the eyeballs, and wide opening of the lids, you see what happens. In spite of her sustained effort the lids gradually fall—the left sooner than the right—until first the iris and then the pupil of each eye is covered. The superior recti also become fatigued so that the ocular axes become horizontal, but this point is somewhat obscured by the drooping of the lids.

The time which elapses between the commencement of the effort and the development of noticeable exhaustion varies considerably. Mr. Bradley observed, on Friday, that the left eyelid began obviously to droop after 25 seconds, and that vision was obscured in 75 seconds. She says herself that exhaustion comes on more rapidly after she has had a restless night.

The other point to which I direct your attention is the fact that after she has been talking for a while the muscles which control the movements of the lips begin to tire, and that those which depress the corners of the mouth, and draw them sideways fatigue more rapidly than the others. The result is that when we ask her to smile for us the upper lip is drawn almost straight up, so that if you look closely you may see wrinkling of the skin between the margin of the upper lip and nose, and the teeth are bared to an unusual extent. This is a common feature of myasthenia gravis and the smile thus produced has been called the "myasthenic snarl" on account of the resemblance to a dog baring the teeth.

There are no other signs of disease. She is well covered with fat; her muscles are well developed, and there is no wasting even of those which fatigue readily. The special senses are normal. There are no abnormalities of sensation; the ordinary reflexes superficial and deep, are readily elicited and are equal on the two sides.

Now I want to dwell for a moment upon the fact that this patient had been diagnosed by various medical men during the past three

years as suffering from hysteria. You can see the line of argument that was followed. Here is a woman who complains of weakness first here, then there. As one set of symptoms disappears, another takes its place. She describes them in a wealth of detail; her story is long and a little tiresome.

"None of the ordinary signs of physical disease are present. Therefore the condition is functional or hysterical."

This is the line of argument that has been followed here, and that has been followed in many other cases of this disease, to the same diagnosis of hysteria.

It is a line of argument which has been proved false in this case, and which is *always* likely to prove false.

The term hysteria has for long served as a kind of diagnostic dumping ground. If a patient has complained of symptoms which were unaccompanied by physical signs of organic disease, and which did not fit in with any of the accepted descriptions of diseases—then the case was functional—and there an end.

Now, there is one obvious fallacy in such an argument. It assumes that our knowledge of the symptoms of organic disease is complete; that if the patient does not present symptoms or signs of one of the organic diseases with which we are acquainted, then he cannot be suffering from any organic disease.

As a matter of fact our knowledge of the causes and symptoms of structural disease is lamentably far from being complete. By slow degrees we are discovering more about them, and it is interesting to note that with this gradual progress of knowledge, diseases which were not so very long ago classed as functional are now known to be organic.

Take, for instance, paralysis agitans. This was for years classed among the functional diseases; now we know that it depends upon minute structural changes in the motor cells of the corpus striatum.

But there is a second and even more important objection to the process of arriving at the diagnosis of hysteria merely by exclusion of the ordinary signs and symptoms of known organic disease. Such an argument is a purely negative process. And we have no right whatever to make the diagnosis of hysteria upon purely negative evidence.

Thanks largely to modern researches we now know a good deal about hysteria. We know that it is essentially a disorder of the mental processes. And of this mental disturbance it is not difficult to find positive evidence by means of common sense enquiry to this end. In the absence of such positive evidence of mental disturbance we have no right to make a diagnosis of hysteria.

I may illustrate this point by the story of another case of myasthenia gravis.

This was a married woman, of 44, who had been ill for four years, complaining of a great variety of symptoms, which all related, however, to her inability to go about and do things. She had been from one medical man to another—this was in America—and had been diagnosed alternately as suffering from hysteria or neurasthenia. She had been in various nursing homes for treatment by psychotherapy which had been constantly unsuccessful.

Eventually she was sent to be investigated as a case of mental disorder to the Psychiatric Clinic of the Johns Hopkins Hospital. Here she was seen by the Assistant Professor—Dr. Campbell. He saw her twice and could find no evidence of mental abnormality. He therefore concluded that she was suffering from some obscure form of physical disease and asked me to see her. From the description I read you from my notes you will have no difficulty in tracing the resemblance to the case you have just seen.

What I want to impress upon you is that Dr. Campbell's argument was just the opposite of that which we hear so frequently. We are accustomed to hear that because there are no signs of physical disease the illness must be mental: *he* said, "Because there are no signs of mental disease the illness must be physical." And he was right.

Since this occasion which impressed me a good deal, I have been in the habit of keeping in mind three categories in the diagnosis of obscure neurological cases. If I can discover symptoms and signs which I recognise as those of bodily disease, well and good—that is Class I. If I cannot find such symptoms or signs, I enquire systematically into the mental state of the patient. If this investigation reveals signs of mental abnormality the case falls into Class II. But if both physical and mental examinations prove negative, then the case passes into Class III., and must be thought

about and investigated all over again from both the physical and the mental aspects. This plan has certainly enabled me to make one or two correct diagnoses in obscure cases.

The other patient who has recently been in the wards suffering from myasthenia gravis, and has since died, was admitted under Dr. Hurst last July.

CASE II.

J. W., a man of 40, a commercial traveller, gave the following history :—

In February of this year he went to his doctor for a violent cough which lasted for about a week. As the cough disappeared, however, he began to lose his sense of taste, and within about ten days it had gone altogether. Thus, greens and potatoes and meat tasted all the same to him. There was no flavour in bread or in a cup of tea. This lasted only for a few days, and was followed by a persistent bitter taste in the mouth which interfered greatly with the pleasure of his eating. Thus, a rich fruit cake would taste as if it had no sugar in it and all the fruit had gone sour. An orange would taste very bitter; a glass of ale unpleasantly sharp. With salt and sugar, on the other hand, he had to take abnormally large amounts before he could taste anything at all. This bitter taste gradually disappeared, but was still present on admission.

On March 25th, five weeks after the first loss of taste, he had some teeth out, a large root abscess being discovered in connection with one of them from which pus was discharged.

On May 15th he observed that when he turned his head to the right he saw things double. This trouble progressed until, at the end of a fortnight, he had diplopia on looking in any direction.

On June 1st he noticed that his jaws got very tired when eating. This got worse, and on June 3rd, after eating a few mouthfuls of meat, he was unable to get his teeth together at all and had to support his lower jaw with his hand.

Then he began to suffer from pain in the back of the neck, which was worse when he bent his head, and he felt as if his head was going to drop off. He noticed this pain particularly when he was digging in his garden, as was his regular habit in the evening. When he stood upright and threw his head back the pain would go, and he never had it while he was lying down.

In the same month he noticed that his eyelids were beginning to droop. This also was particularly noticeable when he was digging or planting, so that his vision would actually become obscured.

At no time did he experience any weakness of the arms or legs.

When I examined him on August 5th I found him a well-built, muscular man of fine general physique and normal mentality. The special senses showed no abnormality except that the various test substances for taste (salt, sugar, vinegar, quinine sulphate) though correctly named, were said not to taste as plainly as they ought.

In the examination of the cranial nerves the most noticeable feature was the permanent droop of the right eyelid. This was much increased when he attempted sustained upward deviation of the eyes. All his ocular muscles were easily fatigued.

The muscles supplied by the fifth nerve showed great fatigability. He was unable to talk for more than a few minutes without having to support the lower jaw with his hand, and had the same difficulty in eating.

The tongue and palate were normal.

He had no hoarseness and no dyphagia.

There was some abnormal fatigability of the muscles of the neck, both those which bend it forwards and straighten it backwards.

His power of consistent effort in all the remaining muscles of his body was better than my own.

There was no abnormality of sensation.

His reflexes were all normal.

Dr. Iredell kindly examined the electrical reaction of the masseters, but could find no gross abnormality.

The Wassermann was negative in blood and spinal fluid. The spinal fluid showed a normal protein content and one cell per c.mm.

The subsequent story is that he was discharged from hospital in the middle of August, and went back to work three days later.

There was marked improvement in the weakness of the jaws, so that he could eat and talk normally.

His diplopia disappeared, but the drooping of the right eyelid persisted.

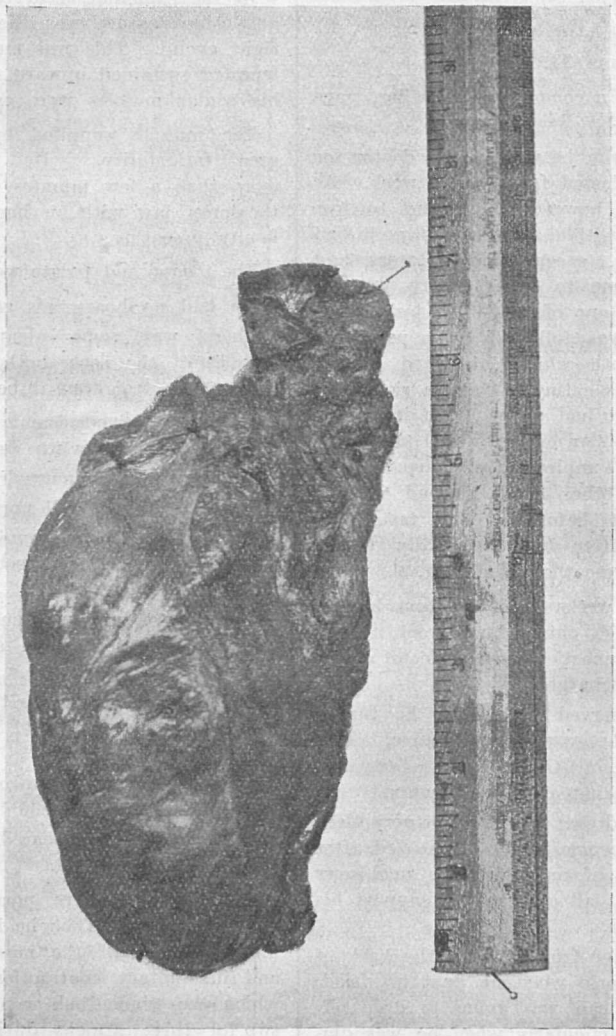
He took an active part in his business up till September 19th. Then he is said to have had twitching movement of the muscles around the left eye, and involuntary contractions of the left leg during which the whole limb would jerk upwards. He had two or three attacks during which his speech became unintelligible, and he died rather suddenly on September 23rd, the cause of his death being somewhat obscure.

At the post-mortem, which was performed the same day, we found as the only gross abnormality this enormously enlarged thymus which lay upon the pericardium and looked very much the same size and shape as his heart.

On cutting open this mass you see it contains a few cysts, but is, in the main, a solid mass. Micro-

scopical sections show it to consist of densely-packed lymphoid tissue.

Our examination of the other tissues is still incomplete, but I can show you sections of one of the ocular muscles in which you can see small clusters of lymphocytes here and there alongside the vessels.



THYMUS FROM FATAL CASE OF MYASTHENIA GRAVIS. (SCALE IN INCHES.)

These collections of lymphocytes were called, by Buzzard, who first described them in this country, lymphorrhages (because of their resemblance to small hæmorrhages). They have since been described by all pathologists who have searched for them in myasthenia gravis, and are to be found not only in the skeletal muscles, but in other organs of the body, the liver, kidneys, suprarenals and lungs. They are, as a rule, sparsely distributed in the muscles. In this case we have had a number of sections made of both superior recti and external recti, but it is only in this one set of sections from the right external rectus that we have discovered the lymphorrhages.

From the account of these two cases you will have been able to learn most of the facts at present known about this disease, which has only been recognised as a clinical entity for the past 50 years, the first paper in which it

was described being published in the "Guy's Hospital Reports, 1877," by the late Sir Samuel Wilks, physician to the Hospital.

Those of you who are interested should look up an excellent summary of the cases reported up to the year 1908, written for the "Reports" of that year by Dr. Morton Palmer.

The illness may occur at any age, but is most common in middle life, and appears to be rather more common in women.

No constant factor has been found in the ætiology, but it has been assumed that the disease is due to some kind of chronic infection or intoxication.

In the pathology the only constant feature is the occurrence of the clusters of lymphocytes.

These cannot be considered as the cause of the muscular weakness; they are not sufficiently numerous; nor does their frequency seem to correspond with the degree of weakness.

Nor can the enlargement of the thymus be held to be a causal factor, for it is only found to be enlarged in about 25 per cent. of the cases, a high enough proportion to show that the association is no coincidence, and that no solution of the problem of pathology can be complete without taking this into account.

So far no one has succeeded in demonstrating definite pathological changes either in the central nervous system or in the peripheral nerves, and the tendency has been therefore—again by a negative process of reasoning—to assume that it is a disorder of the muscles.

This, however, is hardly justifiable. Our knowledge of the picture of disease within motor cells is yet far from complete, and it is possible that future methods may reveal changes which have so far passed unnoticed.

Abnormalities have been recently described in the metabolism of sugar and creatin in these cases, but this cannot be accepted as evidence that the disease is of muscular origin. Changes of this kind may well be secondary to the condition of undue fatigability.

On the other hand I think there are some arguments which favour the theory that the disease is nervous in origin.

One is the not uncommon occurrence of sensory symptoms in the form of pains or numbness. Particularly striking in this respect was the loss followed by perversion of taste in the second case I have related.

A second point is that in a case which I investigated with the ergograph, I found that after the flexor sublimis digitorum had been fatigued to a standstill by means of voluntary contraction, immediate stimulation with the faradic current gave a response almost equal to that produced by the same current before the series of voluntary contractions was commenced, as this record shows. This indicates that the fatigue is of the central nervous apparatus rather than of the peripheral nerve or muscle.

You will read in the text-books of the myasthenic electrical reaction. The muscles in this disease are said to be readily fatigued by faradism, but when so fatigued will still respond to galvanism. This reaction has not been typically present in any of the four cases which I have examined, and I do not think it is of great value in the diagnosis.

The prognosis is on the whole very bad. The danger is of the weakness—or rather fatigue—affecting the muscles of respiration, especially the diaphragm, when the patient dies of suffocation.

In such case it is always worth while applying artificial respiration and keeping it up for several hours. After such treatment patients have been known to recover and live many months.

The two cases which I have related to-day probably represent the extremes in prognosis. The majority of patients with this disease die within 2 or 3 years from the onset of symptoms, but some have been known to live for 18 or 20 years.

As to treatment there is no doubt that periodic rest, and avoidance of fatigue are beneficial. The first patient has managed to adapt herself to the situation and get through her work with a minimum of muscular effort.

Effective treatment must aim at removing the cause, or better still protecting the patient against it, and this cannot be begun until the causal agent is discovered. This then, as do so many other diseases, presents a problem for the research worker.

In the case of the man who died one is tempted to believe that the root abscess in his mouth was connected with the ætiology of his illness, especially as his illness began with symptoms referable to disease of the sensory part of the fifth nerve, and then were followed by others, all of pontine or bulbar distribution.

It seems possible that bacteria or their toxins may have ascended by way of the perineural lymphatics and so gained access to the nuclei of the brain stem.

We know from experimental evidence that these perineural lymphatics provide one pathway of infection of the central nervous system, and we have, in diphtheria, already one striking example of the way in which an organism established within the mouth may by this route infect the cranial nerve nuclei.

I hope that those of you who meet with early cases of the disease will bear this possibility in mind and carry out bacteriological investigations.

Voices from the Past.

(Continued.)

The District Around Guy's.

Fifty years ago ninety-nine per cent. of the Guy's men lunched or dined at either the "Half Moon" or "White Hart." Those who preferred something lighter in the middle of the day used to go to a confectioner and pastrycook shop at the corner of Newcomen Street.

It was kept by two old ladies, and was very clean and in every way worthy of the thriving trade which it attracted. It was a very great shock to all those who had been in the habit of taking their lunch there, to hear that it had been broken open, robbed, and its quiet, inoffensive proprietors cruelly bashed on the head and killed. It gave rise at the time to much sympathy amongst Guy's men, but the Gazette was too young and feeble to take any steps or even say much on the subject. It was strongly felt by a large number of people that it was plainly the duty of all those who exercise authority over the London area to take much more effective steps than at present to eradicate the large and buried slum areas such as surround Guy's on all sides. Buried and hidden from view of the many frequenters of the main arteries of the district, the inhabitants constitute a real danger to the rest of the law-abiding population. It may be said to be a stagnant, septic mass of no physiological value, but a lump of degenerate tissue which ought to be excised wherever possible, freely and effectively. Where this is impossible, then free incisions should be made into it and antiseptic measures taken. Free drainage is one of the best, such as has been done in other parts of London by running straight, broad streets through the districts. The foul population of these shut-off yards and squares soon disappear when a good active circulation is established. It is the first duty of a Local Government to, first of all, remove these large septic, non-productive masses, so that their place may be taken by houses and homes available to the genuine workman. At present they are homes of vice and crime, shut off, secluded cavities without any proper circulation and therefore fore-doomed to be the home of septic and microbic life, a danger to all around.

I know something is being done; but to my mind, it is not radical enough. It reminds me of what I once saw as a boy, before I knew Guy's. A man lay in pain on his bed. The doctor said, "Something must be done; you require an operation; you are in pain because you have something deep down buried in your leg which requires removing and the place sweetened." An old greybeard was called in consultation, and he made an incision, but left the man in as much pain as ever. The professional formality of the business had been fulfilled, but not the surgical necessity. When the back of the greybeard was turned, the doctor who had just said an operation was necessary, took up the knife, and plunged it deep into the calf through the new incision. There was no chloroform given, but down went that knife until the blade, and a good portion of the handle was buried and the point of the blade touched the bone. Up came the pus mixed with blood and clots, and up came the pain too. The doctor said he had "relieved tension," but I can see now that he had got, what I afterwards learned to call, a case of infective periostitis. His surgical mind knew

that it was not only an incision that was required, but an effective incision, one deep enough, and long enough, to give relief and effect a cure. It is no good to potter and tinker; you must clear out the evil.

I was a boy then, but I was old enough to learn the lesson. So, also, these slum areas and districts are always confined spaces at the back of big roads and between big thoroughfares; they are not even "backwaters," they are like silent pools behind a stream, a stinking swamp. It is no good to pull down here and there, and build a chapel or a church. The remedy, to be effectual, must be radical.

A very short time ago I passed by the shop where the old ladies were murdered, and began to explore Kent Street and its neighbourhood. I soon found that I was beginning to attract attention and if I wished to be safe, it behoved me to retire. There had been some slight alterations and improvements, but it was practically unchanged.

From the earliest breath, the GAZETTE has known these large areas round Guy's to be the home and breeding ground of vice and crime of the foulest and most brutal description, yet beyond widening and beautifying Mint Street, and a few trifling "incisions," the bulk of the mass has remained untouched. What are the Powers about? Are they building themselves fine offices? Architectural monuments to rival even the temples of Rome and Greece in their beauty? Or are they just widening and improving streets whose only fault is they are too narrow or crooked? These may be inconvenient, but they can wait. There are more important things than beauty and convenience to be seen to.

Let them not only open up, but eradicate the great mass, which is not only an evil to itself, but a curse to everything and everybody in its vicinity.

When I see streets being widened, and buildings made more beautiful, which enclose behind them large areas of narrow streets and blind alleys, it suggests those dentures which I sometimes see in people's mouths, a show of rosy gums and pearly teeth, placed upon, and in front of, the old rotten stumps: a useless, ineffectual adornment put there to gain an easy, cheap, and quick reward.

Let these fine frontages be made to give way to a total clearance of the old effete residues and in their place plain, straight, useful substitutes. After utility has been gained, then ornamentation may be considered, but there can be no true beauty in a meretricious gaudiness which covers up vice or an attempt to decorate what ought to be ruthlessly removed.

To say that I was "disappointed" at the Bermondsey slums being still in evidence, is to put in a mild form the sorrowful indignation I felt at the supine neglect of the authorities allowing such collections of crime and vice, such relics of impurity and disease, to exist as a striking comparison of the wide divergence in type between the morally septic and neglected crime-breeding grounds of the Borough and the modern advancement in practical science, with all its consequent benefits to mankind as is seen in the laboratories and lecture-rooms of Guy's Hospital; where seeking, not avoiding, the unknown; investigating and pursuing, rather than shunning, unseen difficulties, and day by day making inroads into the hitherto concealed, they are able to remove those errors, which have already lain too long as obstacles to civilisation, and, in their place, building up monuments of Truth, more enduring than bronze, not only beautiful in themselves, but giving strength to the puny and feeble, they afford a noble example of progressive activity to the blatant incompetence of Bumbledom.

GUY'S AND ST. THOMAS'S.

The early numbers of the GAZETTE were just in time to see the last vestige of the old St. Thomas's Hospital in St. Thomas's Street. Guy's and St. Thomas's Hospitals were both in the same street, and formed what was known as the "United Hospitals." The greater part of St. Thomas's was demolished to make room for the railway extension, but one block was

left standing on the north side of St. Thomas's Street for some years after, the work meantime being carried on in Kennington Park, whilst the new buildings opposite the Houses of Parliament were being erected. They were built in blocks, as this plan was then firmly believed to solve what was then the nightmare of hospital treatment, infection and increased severity of type caused by crowding.

This was before Lister's time. There is yet much to be said on the subject of ventilation and over-population of large areas as the causation of ill-health, but the question of septic inflammation which was the greatest terror, more than all the rest put together, was solved by Lister's discoveries and his method of destroying and inhibiting germ-life alone.

In the opinion of many we have now solved all the great outstanding problems; the rest is a question more of details. I am not so sure of that. It seems to me that there are yet difficulties to be overcome and more mighty problems to be met than any that have yet been achieved, and I doubt not that the GAZETTE will live long enough to record more weighty announcements and more wide-reaching discoveries than any that have been ever before recorded by any medical journal.

Here is one—The Sewage of the Air. Stand outside any of our large manufacturing towns, such as Birmingham, Sheffield, Gateshead, and see the innumerable tall chimneys pouring forth all day long into the atmosphere immense thick clouds of free carbon, carbon dioxide and the deadly carbon monoxide as well as many compounds of nitrogen, sulphur, etc., not only robbing us of oxygen and its equally valuable ozone, but filling up their places with noxious and poisonous relations.

Why should this be? Why should our air for breathing be tampered with and vitiated any more than our drinking water. One is as important as the other and much more insidious.

Before some of these carbons and carbon compounds can be again taken from the air, and oxygen substituted, they have to be slowly carried away to the distant areas of leafy trees and grassy prairies, perhaps thousands of miles away, meanwhile freely inhaled by the people who have been in towns and cities all day, the very ones who ought not to do so. Why should this aerial sewage not be isolated until it can be utilised and fixed? Why allow it to mix promiscuously with the air of our towns and to come in at our bedroom windows when we open them to let in a little "fresh air?"

Again, England long ago became unable to feed all her own population. She has to make large drafts on the farming and agricultural land of other countries. But these same countries are now going the same road as England has gone. They are increasing their town areas and reducing their open air spaces. It is only a question of time for these two factors to balance each other, when it will take the produce of every available acre that can be put under cultivation to provide food and clothing for the thousands of millions of people who are starving for food. This condition postulates one of two measures: Either a scientific solution of the problem, or the almost universal death from disease, overcrowding and starvation, of the population of nearly the entire globe. When the lights are low and the earth is still and one's thoughts slide quietly along the old beaten tracks of memory and try and peer darkly into the future, it seems to me sometimes when I read of traces of civilisation in parts of the world now almost untenanted, that such has already been the case and we are the children of a remnant of a great people long since passed away. It may be, or it may not, but it is an old man's dream of the future. We shall pass into oblivion, but the GAZETTE will go on and perhaps see in its time a remedy found for what has hitherto proved an insuperable obstacle to science, viz., the proper disposal of the Sewage of the Air and the scientific feeding and nutrition of our tissues without recourse to farming or agriculture.

THE EVELINA HOSPITAL.

At the time of which I write—54 years ago—the Evelina Hospital in Southwark Bridge

Road, had chiefly Guy's men on its staff. I was then holding the appointment of Registrar. The House Surgeon was an Irishman, well qualified and keen on his work, but his shillelagh was always in his right hand ready to dispute with, and knock even his best friend down, on any question which he liked to raise. The Registrar had also to give anæsthetics, so, what with one thing or another, it was a very useful and intellectually lucrative appointment for a senior student to hold. It had been built originally by one of the Rothschild's as a tombstone in memory of his wife, "Evelina," whose death was said to have distressed him severely. It was first opened as a Hospital for Women, but was quickly altered to one devoted to Children alone.

WHOOPING COUGH AND PNEUMONIA.

I remember distinctly some very interesting facts which I learned there, of which I before was profoundly ignorant, and on which I found students generally no better informed.

One day I happened to remark to the H.S. that one of the children was suffering from whooping cough and pneumonia. "Why do you say 'and' pneumonia?" he asked. "Why shouldn't I?" I retorted. "Because," said he, "it is always the case. I challenge you to show me a case of whooping cough that has not got also pneumonia!"

(To be continued.)

Papers by Guy's Men.

H. W. Barber, M.B., M.R.C.P. The Seborrhœic State.—*B.M.J.*, ii., 1922, p. 754.

J. M. H. Campbell. The Relative Volume of Corpuscles and Plasma, and the Relation of this to Hæmoglobin percentage, and the Number of Red Blood Corpuscles.—*Brit. Journ. Experimental Pathology*, Vol. III., No. 3, October, 1922, p. 217.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Notices.

Notice is hereby given that at a meeting of the Clubs' Union Council, held on Tuesday, October 10th, it was decided to appoint Mr. Arthur Shepherd, of 7, Cornmarket Street, Oxford, as the Blues Outfitter to the Guy's Hospital Clubs' Union.

Mr. Shepherd will attend the Hospital on one afternoon per week, if necessary, and the charge for a blazer and badge complete will be £3 (three pounds).

The Clubs' Union Council also adopted the recommendation of the Blues' Committee to award four full "Blues" per annum to the Swimming Club.

Hockey.

GUY'S v. CITY OF LONDON H.C.

Played on Saturday, October 7th, at Elmers End.

For this match, the first of the season, Guy's had a much depleted team and were lucky to draw, 2—2, after being a goal down at half-time. For the Hospital, Dunnitt in goal played a sound game, while Bonnalie was the pick of the backs. Hooper played his usual brainy game at right half, but Ford in the centre, though working hard, was inclined to be slow. The forwards showed little combination and were all over the place due probably to the fact that, owing to two of the team taking the wrong train at London Bridge and not arriving in time, two substitutes had to be brought into the forward line. The Guy's goals were scored by McHousden and J. G. Kingsbury.

Rugby.

GUY'S v. GLOUCESTER.

To the City of Gloucester the Hospital XV., without their captain, Albertijn, and also minus the assistance of Duncan, journeyed on Saturday, October 14th, and there met defeat from the home XV. We were beaten, and by a side which on the day were decidedly better than us both fore and aft, but especially at stand-off half where T. Millington was excellent. Sprong did not watch him with anything like sufficient vigilance, and appeared non-plussed by the Gloucester fly-half's tactics.

We had the sun in our faces to start with and soon worked down to the Gloucester "25," but a penalty kick sent us back. However, we were soon attacking again, but the threequarter machine was not quite in order—plenty of passing, but not much gain. Then the Gloucester pack got us on

the retreat and gained foothold in our "25." Millington had a shot at goal. The ball, however, scarcely left the ground. Just after Hall, a home forward, gained a try and Millington converted. Daneel saved well on more than one occasion, and Guy's defence was sorely tried. Just after a score for the Hospital looked certain, but Steyn held on too long. Before the interval Daniell beat Daneel and a wide try going without conversion left Gloucester 8 points up at the interval.

Surely no man ever tried so hard as W. D. Doherty to pull the game round. He played like a man possessed right up to the final whistle. Taylor backed him bravely, but our efforts were not successful. The ball, when it came to the backs, was not handled with precision and the home pack, playing at their very best, were always on to our quartette. Ere the final whistle, Millington, who had a day out with a vengeance, scored and converted his own try. But he failed to convert a try gained by Brown, just before the game ended. It was a very hard game. The Gloucester forwards are a very tough lot; true, Holford was not playing; S. Smart, F. Ayliffe, T. Voyce, A. Hall and Major Roderick, however, take some checking, especially on their native heath. Result:—Gloucester 2 goals 2 tries (16 points), Guy's Nil.

Guy's Team.—S. H. Daneel, A. Hirschberg, J. G. Van Schalkwijk, C. L. Steyn, G. R. Mostert, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, E. E. Neser, F. J. Biddle, G. Zondagh, B. G. Scholefield, N. M. Holloway, F. G. Hutchinson.

Award of Blues, 1921–22.

RUGBY FOOTBALL.

Full Blue.—E. H. Fouraker.

Half Blues to Blues.—A. K. Van Niekerk, E. L. Sprong, F. J. Biddle, P. G. Harvey, L. K. Watson, G. Zondagh.

Half Blues.—H. G. Close, N. M. Holloway, F. G. Hutchinson, J. S. Jacobsz, J. W. Schabort, H. K. Williams.

ASSOCIATION FOOTBALL.

Full Blues.—O. F. Painter, S. E. Sennitt, L. Walker, V. R. Morgan.

Half Blues.—W. Nicholls, C. B. Parry, W. Wayman, T. Wooldridge, F. Nicolai, L. W. Cann.

ATHLETICS.

Full Blue.—P. K. Albertijn.

Half Blue.—F. G. Hutchinson.

HOCKEY.

Full Blues.—C. G. Bowen, H. Slater, K. Hooper.

Half Blues.—G. W. Gathergood, J. G. Kingsbury, D. C. Eglington, I. P. Spurrell, E. G. Smallbone.

BOXING.

Half Blues.—N. M. Holloway, J. G. S. Thomas, C. S. Gross, G. V. Lloyd-Williams.

SWIMMING.

Half Blues.—W. E. Silver, G. B. Kempster, S. E. Theis, F. A. Sampson, F. R. Dingle, C. A. Wakeford, H. Richards, J. Simons.

GOLF.

Half Blues.—L. W. Cann, C. W. Greenway, D. G. Bown, D. B. Whitlock, F. James, J. P. Evans, F. E. Graham-Bonnalie.

RIFLE CLUB.

Half Blue.—H. O. Eksteen.

CRICKET.

Full Blue.—L. S. Williams.

Half Blues.—C. Arkles, N. H. Saint.

TENNIS.

Full Blues.—H. Lewis-Phillips, R. Schlimmer.

Half-Blues.—W. Badenhorst, P. R. T. Becker, E. V. Potts, E. N. Sharpley, A. Gordon, P. Albertijn.

CROSS COUNTRY.

Half Blues.—S. E. Theis, J. G. S. Thomas, J. L. Faull.

The Golf Club.

The return match—Staff v. Students—was played at Northwood on October 25th, and resulted in a draw, 5½ matches to 5½.

Dr. Cameron	...	0	L. W. Cann	...	1
Mr. Mollison	...	0	G. Gathergood	...	1
Mr. Davies-Colley	...	0	F. E. Graham-Bonnalie		1
Mr. Scott	...	1	F. W. Schofield	...	0
Mr. Chapple	...	1	J. P. Evans	...	0
Mr. Mollison	...	1	D. J. Bown	...	0
Dr. Ryffle	...	0	C. W. Greenway	...	1
Mr. Hughes	...	0	G. D. Shaw	...	1
Mr. Fagge	...	1	D. B. Whitlock	...	0
Mr. Pearce	...	1	H. Moore	...	0
Mr. Rowlands	...	½	J. C. Dickinson	...	½
		5½			5½

Golf balls kindly presented by Dr. Cameron for the best bogy score were won by L. W. Cann, 2 up; F. E. Graham-Bonnalie, 2 down.

Birth.

THORNTON.—On October 13th, 1922, at the Nursing Home, Trebend Street, Leicester, to Grant and Winifred Thornton (née Fawkes), the gift of a daughter (Mary Joy).

Marriage.

JERWOOD—EVERITT.—On October 10th, 1922, at St. Paul's, Mirfield, by Canon Jerwood and the Rev. C. A. Maughan, Bernard Elleray Jerwood, of Oakham, to Barbara Joan, eldest daughter of Mr. and Mrs. W. G. Everitt, of Eastthorpe House, Mirfield.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE activities of the Physical Society, lectures by men who have known the great surgeons of a previous generation, and articles in the GAZETTE recently have familiarised our readers to some extent with the debt which we owe to these great men of the past.

On Thursday the members of the Physical Society attended a lecture by Dr. Leeson (who was one of Lord Lister's dressers) upon some of his memories of his chief.

Dr. Leeson can tell a good anecdote as well as anybody, and we know that the ovation which he received at the end of the address expressed not only our homage to Surgery's greatest name, but also our appreciation of and delight in Dr. Leeson's gifts as a *raconteur*.

By a happy coincidence, the concluding chapters of the article on "Voices from the Past," which we publish in this issue, also give some attention to Lord Lister and the surgical revolutions which he effected.

Moreover, we publish to-day the account of Sir Charters Symonds' Inaugural Address to the Physical Society, dealing with Guy's Surgeons in the past, so that a considerable portion of this issue is devoted to an account of those men to whose efforts we owe so much.

THE work of Guy's surgeons must be, to the mind of one who frequently visits our Museum, a subject inseparably connected with the name of Joseph Towne, the modeller, whose admirable execution of models from Hilton's dissections still remain a unique feature of the Museum.

It is interesting to note that Towne did not confine himself entirely to anatomical subjects, although these must necessarily have occupied most of his time.

An interesting and valuable addition has been made to the Guy's Museum of Antiquities by the presentation to the Hospital of a Statuette of the Duke of Wellington. This wax model, which was bequeathed by Miss E. M. Towne, the distinguished modeller's daughter, may be viewed at any time on application to the Wills Librarian.

AN old Guy's nurse, who is in possession of a duplicate copy of No. 1 of the GAZETTE, writes to ask if we think it is of any monetary value. We do not believe that it is of any great intrinsic value, but it may be of great sentimental value to some old Guy's man who does not possess a copy, and we shall be pleased, upon request, to put those desirous of obtaining the copy into touch with the present possessor.

In accordance with their usual generous custom, Messrs. Ash & Co., the publishers of the Gazette, have printed a number of Christmas cards, upon which are pictures of various views of the Hospital, and presented them to Guy's, the proceeds of their sale to be devoted to Hospital funds. These cards can be obtained from Miss Smith in the Matron's Office or Mr. Winston in the Library.

We are asked to draw the attention of senior men, Residents and others who are able to attend, to a lecture by Dr. W. McC. Wanklyn, B.A., D.P.H., M.R.C.S., Principal Assistant M.O.H. to the L.C.C., which will be given in the Anatomical Theatre at Guy's at 5 p.m. on Monday, November 13th.

The subject is the Diagnosis of Smallpox—surely one which none can afford to neglect in these days, when the diminution in the incidence of smallpox which followed the universal adoption of vaccination has been to a certain extent nullified by legal recognition of anti-vaccination cranks and conscientious objectors.

The new University Union Buildings, which were opened by Lord Haldane recently, are now available as a club for members of the Union. We have heard from an ardent supporter of the Union that the tedium of official proceedings was relieved, upon the occasion of the opening ceremony, by a wireless concert which followed the formalities. Unfortunately, we are told, the spirited rendering of somebody's Aria by somebody else was ruined by an unknown distant comedian, of the same wave-length, butting in with a song to the effect that he did love singing in his bath.

It will be seen that since the rebuke administered to us by one of our correspondents upon the subject of Medical Education, we have refrained from comment upon such burning topics as "Should a Doctor Tell?", or "Do Athletic Women make the Best Wives?", abandoning ourselves to less momentous questions with that airy discursiveness which our correspondent appears to admire so much.

Hospital questions, however serious, still form a legitimate field for Editorial comment, and it is with this apologia that we venture to approach a subject of great importance in the education of every Guy's man.

The question which we wish to ask is this:—"What has happened to the 'Guyoscope'?"

There has been some dissatisfaction recently at the decision of the College Committee to enforce the rule that men living in the College shall pay a deposit of five guineas as a guarantee in case of damage to furniture, or failure to pay rent. It is felt that it is annoying for men who have lived quietly in the College for, say, a year, without doing more damage than the smashing of a toothglass or the implanting of a forbidden nail in the wall, to be asked, quite suddenly, for a deposit of five guineas.

We are glad to say that the College Committee have taken up a considerate attitude. We are assured unofficially that payment will only be enforced in the case of newcomers to the College.

We congratulate Guy's teachers upon the examination results published in this issue. In Medicine 63 per cent. of the candidates passed, in Surgery 77 per cent., while in Midwifery the high rate of 81 per cent. has been reached.

Thirteen men qualified on this occasion, have completed the whole examination.

A Case of Acute Hæmorrhagic Pancreatitis.

Wm. McG., æt. 60 years, a work checker, was admitted for acute abdominal pain and collapse, 18th November, 1921, under Mr. Rowlands.

History.—The patient was run over the abdomen by a four wheeled vehicle 36 years ago. He was an in-patient at the infirmary for a fortnight, and fully recovered after two months' rest and treatment.

For fourteen months before admission he has been attending Out-Patients for heart trouble. He has been suffering from abdominal pain for the last two or three years, not badly enough to prevent him working. Two years ago he had a short attack of jaundice, which was accompanied by attacks of vomiting, occurring two or three hours after meals. The vomit, which was of a yellowish slimy appearance, was very profuse. The urine during this attack was of a brick red colour. There is no history of constipation, and the motions are normal. Micturition is normal. On day of admission he had a heavy breakfast (7 a.m.) which was followed by a sudden attack of acute pain. He struggled to work, and about 10 a.m. he had a severe attack of vomiting, the vomit being grey and frothy. He felt very cold and perspired freely.

C.O.A. (6 p.m. 18th November, 1921).—The patient, who was in great pain, cold and shivering, and in a state of collapse, was rather obese and pale. Temperature, subnormal; Pulse, small and rapid; Respiration, 30, shallow.

On palpation he was very tender over the liver and in the right epigastrium slightly to the right of the umbilicus. The abdomen was distended.

Operation.—Mr. Ogilvie, who operated, made a paramedial incision. The peritoneum contained a bloody fluid, and on opening the lesser sac a number of blood clots and numerous patches of fatty necrosis were found. The head of the pancreas was very hard and infiltrated with blood, and the body was enlarged, the whole having a mottled appearance. The irritative fluid was mopped out. Stones were felt in the gall bladder, but the patient was too badly shocked to allow of anything else but drainage to be done. A rubber tube was placed into the lesser sac and one against the gall bladder to provide a free outlet to the surface for trypsin and toxins. The wound was then sewn up. The patient was then put to bed having an electric cradle put over him in addition to hot water bottles. He was also given rectal saline and

Omnpon gr. 1/3, 12 midnight.
I.A.H. gr. 1/100, 2.30 a.m.
Curschman m. v., 3.15 a.m.
Strophanthin gr. 1/250, 3.50 a.m.

His temperature remained subnormal and pulse rate rose to 160.

Patient died at 7 a.m., 19th November, 1921.

Autopsy.—The left heart was somewhat enlarged, left ventricle, wall very thick, with atheroma of the coronary vessels. Patches of fat necrosis around the pancreas, in omentum, etc., a small stone in the ampulla of Vater. There were signs of a chronic cholecystitis with many small stones in the gall bladder. There were many small stones at the junction of the cystic and hepatic ducts, and in the course of the common bile duct, which contained five stones. There was no sign of jaundice. The pancreas showed normal tissue with the islands surrounded by hæmorrhages. Liver normal. Kidneys somewhat granular, the one capsule stripping rather easily, while the other was very adherent and the pelvis enlarged. There were signs of old perisplenitis, the diaphragm being adherent to the spleen. Intestines were normal.

Acute pancreatitis is said to occur chiefly in males inclined to fat, and with a previous history of indigestion. The pancreas is entirely retroperitoneal, and therefore is the most "silent" of organs. It is for this reason, and, the frequency of a history pointing to disease of neighbouring organs, that a definite diagnosis of acute pancreatitis is seldom made. It is generally mistaken for one of the following conditions in the order stated:—

1. High intestinal obstruction; because of the frequent vomiting and obstinate constipation coupled with the absence of the physical signs of peritonitis.
2. Perforation of a peptic ulcer; because of sudden onset and extreme collapse.
3. Perforated gall bladder; history suggesting perforation and previous story of gall stones.

4. Perforated appendix.
5. Acute cholecystitis.
6. Mesenteric thrombosis.

As in this case there is very often a previous history of jaundice suggesting gall bladder trouble. The onset was sudden with an agonising pain, following on a heavy meal. But as compared with a patient suffering from a perforation, who never moves from the place where the pain has felled him, this man actually struggled to work. The rigidity was not very marked as compared with that in perforation or acute cholecystitis. The collapse in perforation or strangulated viscus is sudden and acute, but it may pass off in four to eight hours, whereas in acute pancreatitis (as in this case) there is no amelioration of pain and the pulse and blood pressure show no signs of recovery.

Loewi's Test is sometimes helpful in diagnosis. One drop of 1/1000 adrenalin is put in the eye. If there is a dilatation of the pupil in a quarter of an hour the result is positive in nearly all cases of acute pancreatitis.

The pancreas may become infected through the duct of Wirsung owing to an impaction of the gall stone in the ampulla.

The autopsy showed the presence of a stone in the ampulla of Vater. In this case the ultra-acute pancreatitis was caused by the ascending duct infection, which is rare. According to White (London Hospital report) it occurs in one case in seven.

The case here described was of the ultra-acute type (Mayo Robson) in which hæmorrhages without inflammatory changes occur. There is an extreme shock followed by death in 48 hours.

I am indebted to Mr. Rowlands and Mr. Ogilvie for permission to publish this case.

A. G.

Change of Address.

F. J. Wheeler, 4, Queen's Road, Southport.

Geo. H. Manfield, Ministry of Pensions, H.M. Prison, Vernon Road, Derby.

St. George B. Delisle Gray, 198, Gloucester Terrace, London, W. 2.

P. R. Bolus, 33, Weymouth Street, W. 1.

L. K. Watson, to 14a, High Street, Watford.

Pass List.

B.Sc. (Lond.)

HONOURS.

Physiology.

1st Class.

W. R. Spurrell. E. C. Warner.

2nd Class.

N. W. McKeith. H. J. W. J. Westlake.

Conjoint Board.

FINAL EXAMINATION. October, 1922.

Medicine.

*D. G. Sharp.	*A. W. Hall.
J. H. M. Lloyd.	*G. M. Stoker.
*H. C. Meathrel.	*W. G. R. Hore.
*D. S. Davies.	J. F. Linklater.
*C. O. Carson.	C. H. Atkinson.
*C. G. Taylor.	M. Markiles.

Surgery.

*D. S. Davies.	*C. G. Taylor.
*A. W. Hall.	*C. Shepherd.
*H. W. Harvey.	H. G. R. Canning.
*F. J. Biddle.	*C. O. Carson.
A. W. Eyles.	P. G. Harvey.
H. J. Plowright.	*H. A. H. Harris.
*G. M. Stoker.	L. Forman.
M. Jackson.	D. B. Whitlock.
M. Weinbren.	H. Evans.
W. G. Booth.	G. R. M. Apsey.
H. C. Beccle.	

Midwifery.

D. H. Hubbs.	D. Davies.
H. C. Beccle.	M. Jackson.
C. A. Probert.	R. H. Amm.
A. Broido.	R. G. Tame.
M. Honigsberger.	T. Wooldridge.
C. G. Bowen.	H. J. Plowright.
G. D. Shaw.	*C. L. Kark.
*D. S. Davies.	R. M. L. Still.
J. H. M. Lloyd.	D. B. Hastings.
*H. W. Harvey.	I. J. Bechal.
F. E. G. Bonnalie.	I. E. Harries.
J. Atkin.	F. James.
N. L. Lloyd.	H. P. Bayliss.
*A. W. Hall.	

*Have now completed the Examination.

Society of Apothecaries of London.

OCTOBER, 1922.

Medicine.

C. F. Parry.

"CHUBBY"
HARCHARD'S
1922
EXAMINATION HALL
UNPLEASANT MEMORIES

The Physical Society.

A meeting of the Physical Society was held on Thursday, October 12th. Tea was served in the Physiological Laboratory and there was the usual exhibition of books and surgical instruments.

At 5 o'clock the meeting moved to the Anatomical Theatre, and Sir Charters Symonds, the Hon. President, gave the opening address. In the absence of Sir William Hale-White, the Society was fortunate in the presence of Dr. Shaw, another Hon. Vice-President to take the Chair.

Sir Charters Symonds began by saying that it was necessary to refer to St. Thomas's from which Guy's was an offshoot, and he exhibited a plan of the district showing the positions of the two Hospitals on opposite sides of the street, and pointed out that the houses between Messrs. Down's premises and the church represent part of St. Thomas's as it was. That nearest the church was, he believed, the residence of the Treasurer. The post office in the Borough occupies part of the more recent building. Guy originally intended his institution to serve as a convalescent annexe to St. Thomas's, but left the Governors full discretion as to what class of case should be omitted. In the exercise of this discretion all kinds of cases were admitted and the service of the two hospitals became identical.

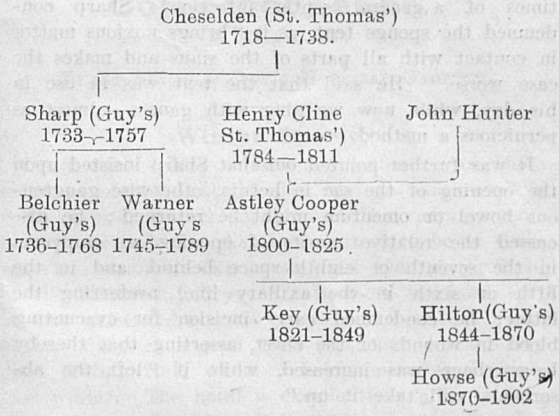
St. Thomas's, he pointed out, had long possessed a medical school and a staff of physicians and surgeons as good as any similar institution at the time. It was said to have the greatest surgeon of the period in William Cheselden, who became an apprentice at the age of 15 in 1703, and sixteen years later was appointed one of the principal surgeons. He it was who improved the operation of lateral lithotomy, and is said to have completed the removal of a stone in 50 seconds, to the amazement of the French visitors. His method held the field, Sir Charters pointed out, down to his own day, and in skilful hands was a brilliant performance. He described the rush to the theatre when Mr. Durham was announced as the operator.

He then showed Cheselden's book on the "Anatomy of the Human Body," which went through thirteen or more editions and contained many surgical observations. The frontispiece, which was thrown on the screen, depicts Hypocrates visiting Democrates to relieve him of a madness, but finding him endeavouring to discover the seat of the bile, pronounced him the wisest man in Abdera. Sir Charters pointed out that the animal under dissection was a pig whose alimentary system more closely resembles that of man than does that of any other animal.

He then showed the "Osteographia," a ponderous volume with life-size plates of the bones, and directed attention to the excellence of the type, the paper—almost a vellum, and the finely drawn plates.

In concluding the notice of Cheselden, who had lectured for twenty years to the pupils at both hospitals, Sir Charters said he was the first who elevated the profession of surgery and made it respected. He is said to have been a keen patron of athletics, especially of boxing, and had a gay and genial disposition, and to his patients was kind and tender-hearted. The portrait was an engraving from the painting in the College of Surgeons, and showed a vigorous, fine-looking man, wearing a kind of turban which, we were told, was of a red colour, as was his coat.

The following table, arranged like a genealogical tree, was written on the slate, and helped greatly in understanding the relationship of master and pupil. The dates after the names are the years during which they were on the staff of their hospital as full surgeons.



The first Guy's surgeon mentioned was Samuel Sharp, who was apprenticed to Cheselden at the age of 24, a friend of the family paying the premium of £300. It was pointed out that as the more usual age to enter was 17 or 18, the fact of Sharp deferring it till 24 suggested that he had had a better general education. Sharp began lecturing at St. Thomas's as assistant to his master, and was appointed surgeon to Guy's in 1833 at the age of 32, holding the position for twenty-four years. Though there was no portrait to be found of Sharp, several of his books were shown, one of which had been translated into French, German and Spanish. We were shown the first edition of the "Critical Enquiry into the Present State of Surgery," published in 1750, which went through ten editions; a small octavo volume of 300 pages, in large type, and it was pointed out that the last edition was no larger than the first. Sharp kept to his text, and dealt with the line of advance only.

Sir Charters quoted many of his views applicable to the surgery of the war. From these there is room for only three :—

"Matter, when it is good, is no dis-service to wounds, and surgeons should therefore be less curious in wiping them clean when they are tender and painful." He said that he had constantly to inculcate this doctrine during the war, and to avoid the horror of the daily dressing he enclosed wounds of the tarsus in a plaster of Paris splint, leaving them for a week to the immense benefit of the patient, but often to the horror of the surgeon who foretold disaster.

Another was : "Not upon all occasions to search into an abscess with finger and probe, as it often tears them open and indisposes them for a cure." He pointed out that though Sharp knew nothing of bacteria he recognised the evil effect of injury where the wound was unhealthy. Again, this practice had, Sir Charters said, often to be condemned during the war, as it was the cause of not only local but sometimes of a general septic infection. Sharp condemned the sponge tent, as it "brings noxious matter in contact with all parts of the sinus and makes the case worse." He said that the tent was in use in his day, while now we plug with gauzes—almost as pernicious a method.

It was further pointed out that Sharp insisted upon the opening of the sac in hernia, otherwise gangrenous bowel or omentum might be returned ; he discussed the relative merits of opening an empyema in the seventh or eighth space behind, and in the fifth or sixth in the axillary line, preferring the latter; he condemned early incision for evacuating blood in wounds of the chest, asserting that thereby hæmorrhage was increased, while if "left the absorbents will take it up."

We were told that Sharp advocated and practised suprapubic drainage of the bladder for retention, and writing of lithotomy, by this route, prophesied that he "would not be surprised if it should be revived with success." Sir Charters said it was one hundred and thirty years before this prophecy was realised, and now the lateral operation is never performed.

Sharp's cylindrical trephine, which he introduced to replace the conical form, was shown, as well as the latter, one from a case used at Trafalgar, borrowed from the Museum; and then the new pattern —a conical one—from the operating theatre. It seems there is really nothing new under the sun.

A final quotation which was appreciated must be given in conclusion : "It is very remarkable that in proportion as the art of operating has improved the number of instruments has generally retrenched, and perhaps the future generations will discuss many of those now in vogue with the present age; at least I am apt to believe that should they attain to further perfection in the art of operating than we are now possessed of, it will possibly be as much owing to an acquired dexterity as to any mechanical invention."

The next portrait shown was one of John Belchier, a photograph taken from the painting in the College of Surgeons. It showed a handsome, aristocratic man in a full flowing wig. He also had been apprenticed to Cheselden, and was appointed surgeon to Guy's in 1736. Though he left no literary efforts, it was pointed out that he must have been a man of influence, and, as his portrait showed, of character, for he was elected a Governor of both hospitals. Belchier was an Etonian.

Then followed Joseph Warner who, like Sharp, came from the West Indies, and was educated at Westminster School where he spent seven years. He was apprenticed to Sharp at the age of 17, and in 1745 appointed a surgeon to Guy's at the age of 28, and retired after 44 years 'service. We were shown the first edition of his "Cases in Surgery," published in 1754, also his works on the Eye and the Testicles. The portrait was a photograph, taken as was Belchier's for this occasion, from the painting in the College, and showed a somewhat dour old man who evidently had an opinion of his own. He wears a close wig. The painting is by Medley, who also painted a group of the members of the Medical Society in which, amongst others, are Babington and Saunders of Guy's. When Astley Cooper saw this painting he remarked :—

"Subject and artist are the same,
Analogy can scarce be stricter,
For Medley is the limner's name,
A medley truly is the picture."

Next was shown a portrait of Sir Astley Cooper, the greatest of Guy's surgeons, taken from Lawrence's portrait in the College of Surgeon's. Sir Charters referred those who were interested in his life to his account in the "Guy's Reports" for January and April of this year. He told some anecdotes of Cooper's boyhood, how he on one occasion scattered the feathers from one of his mother's best pillows from the church tower to the consternation of the village. Then we were shown the great work on Hernia, with life-size plates; the beautiful coloured illustrations of injected lymphatics, from his work on the breast and on the testicles. And lastly the specimen from the Museum of ligatures of the external iliac for aneurism. Sir Charters described how this was obtained some years after, injected, and dissected. He told us that so great was Astley Cooper's dexterity acquired by experiment on living animals that he had ligatured both the carotids and both vertebrals in a dog in half an hour.

It is interesting to recall how the great surgeons, such as Astley Cooper, Lister, and John Hunter, take,

perhaps, an even higher place as men of science than as practical surgeons, and how their work and experiments are still referred to by physiologists and pathologists.

A portrait of Aston Key, one of Astley Cooper's apprentices, was next shown, and we were told the story of the first successful ligature of the subclavian in London. Sir Charters had been told this by Mr. Bryant who said that on visiting Mrs. Key some fifteen years or more after the event, she produced the ligature for his inspection. Key, we were told, was the first surgeon at Guy's to employ ether—very soon after Liston, who operated under this anæsthetic for the first time in England in 1847. Key died of cholera in 1849. The preparation of the subclavian artery in our Museum, showing the anastomosing vessels, obtained twelve years later, was exhibited.

He then spoke of Hilton, and showed his portrait and the first edition of his memorable book on "Rest and Pain," explained how it was the outcome of 17 years spent in the study of anatomy and physiology, during which time he made the beautiful dissections from which Towne executed the unique models in our Museum. Hilton was appointed assistant surgeon in 1844 at the age of 40 and full surgeon five years later. It was not till 1860 that he gave his first lecture at the College on Rest and Pain.

Sir Charters urged us to read from the original edition in the library, as the page was large, the print good, and one seems to get into closer touch with the author. These classical lectures, he pointed out, had lost nothing of their original value. In the lecture by Dr. Ryle, published in a recent number of the GAZETTE, Hilton's work was drawn upon to explain viscero-reflex phenomena.

Though more than an hour had elapsed, Sir Charters was unwilling to close without a few words about Henry Howse (afterwards Sir Henry), for he it was who introduced antiseptic surgery at Guy's, and with Marcus Beck, of University College, into London. This, he said, marked an epoch in the practice of surgery in our hospitals. Had time permitted, Sir Charters would have liked to tell us of the revolution he had seen effected by the work of Sir Henry Howse.

It is impossible in this summary to give any idea of the charm of the lecture. Every man came away with a clear picture of a few of the great Guy's surgeons. They were pre-eminently men of character and hard workers, and again and again Sir Charters reminded us of the courage which was needed both in surgeon and patient to carry out large operations in the days before anæsthetics. One cannot help being struck by the amount of time which they gave to research, to dissection, and injection of the vessels by coloured wax and quicksilver, and later to experiments, generally, spending several hours a day in the laboratory in their own houses.

The obvious love of Sir Charters Symonds for his predecessors and his delight in the fine collection of books and portraits which he had to show was certainly infectious and added much to the enjoyment of the evening.

Dr. Lauriston Shaw proposed a vote of thanks to Sir Charters Symonds for his address, and Mr. Ogilvie in proposing a vote of thanks to Dr. Shaw for taking the chair, pointed out how pleased the present generation were to welcome back members of the Visiting Staff.

After these had both been carried with acclamation the meeting adjourned, but it was a long time before Sir Charters was able to get away from answering questions and showing at closer quarters the old books he had spoken about. Many of these had been the property of the Physical Society and are now in the Guy's Library.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Winter Sports.

DEAR SIR,— May I draw the attention of those members of the Clubs' Union who are interested in Swiss Winter Sports to the fact that arrangements have been made for the Headquarters to be at Griesalp this winter. This is an ideal spot at the head of the Kienthal Valley (5,000 ft. above sea level). It is very quiet and the scenery is most beautiful. Excellent Ski-ing, a good luge run, and a reasonably good skating rink, which is being enlarged, I think, this winter. The hotel is excellently run, is modern and very comfortable. Full Pension, with afternoon tea, will be from 15 francs according to a letter I have received this morning from the Proprietor. With the exchange nearly normal, 24 francs, it will be seen that it is cheaper than any holiday resort at home. The best time to go is towards the end of January and the whole of February, when one can be pretty certain of snow and frost.

Leaving London at 2 p.m., one arrives at Spiez next morning, and a connection for Reichenbach on the Loetschberg Railway leaves immediately. From here a sleigh provided by the Hotel conveys one up the Valley, three hours' run through the most entrancing scenery to the Hotel. Ski luges, etc., can be hired there, but old hands at the sport will know their own requirements.

Any other information can be obtained from the Proprietor of the Hotel, M. Scheurer, Grand Hotel, Griesalp.—Yours truly,

PERCY H. HICKMAN,

6, Nelson Crescent,
West Cliff, Ramsgate.

Notices.

The 16th International Motor Exhibition.

THE DOCTOR'S LIGHT CAR

Those who were fortunate enough to visit the 16th International Motor Exhibition at the White City and Olympia, must agree that one of the chief outstanding features of the Show was the enormous variety of the exhibits.

Every type of car was represented, from the 40/50 Rolls Royce *de luxe* to the lightest of Light Cars—the 1 h.p. Baby Pram.

The ordinary Light Car, suitable for Medical Men, was there in a hundred varieties, at prices which would have been considered impossible a few years ago; for although the Light Car is a comparatively recent development of the Motor Industry, such has been the demand for this type of Car, that it has now become one of its most important branches of manufacture.

Fitted with all the latest improvements, handsomely upholstered, and complete with all attachments, these Cars can be purchased at prices ranging from £160 to £450.

It is, of course, advisable to discriminate, for although all are wonderful productions for the money, a Medical Man must have a RELIABLE CAR.

Imagine a breakdown on the way to an urgent night call and its possible consequences!

There are, however, plenty of good Light Cars to be had at prices from £250 to £450.

An excellent exhibit in Light Cars is the 12 h.p., 4 cylinder model, made by Messrs. Auto Carriers, Ltd. This is a most comfortable car, beautifully fitted, and thoroughly reliable in every way, and is well worth the £400 asked for it.

A good strong car of handsome design was shown by Messrs. Harper, Sons & Bean, Ltd., well suited to the requirements of doctors. This car deserves its rapidly growing popularity, and is, perhaps of all others, one of the most improved of post-war models, price £400.

As another example, we may mention the 10 h.p. Swift 2-seater, 4 cylinder engine, water-cooled, self-starter, electric lighting, etc., etc., the price of which is £275, complete with all attachments.

There are, of course, many more good Light Cars with which we cannot deal here, but enough has been said to assure our readers that a good reliable Light Car has now been brought within easy reach of all those contemplating a purchase.

International Matches.

Will those who require tickets for the England v. Wales match at Twickenham on January 20th, 1923, please let me have their names, number of seats required and cash as soon as possible. Seats, (1) Covered Stand 10s. each; (2) Ring Side for Players only 5s.

This is under the new arrangements made at the last General Meeting of the Rugby Union. Messrs. Hayes no longer supply seats to members of clubs

S. P. MEACOCK,
Hon. Sec, R.F.C.

The Car & General Insurance Corporation, Ltd., 83, Pall Mall, S.W. 1, have taken Stand No. 334 at the Olympia Show for the convenience of their clientele and others desiring information relating to Motor Insurance.

Voices from the Past.

(*Concluded.*)

One of the larger wards was entirely devoted to whooping cough. It was always endemic and sometimes very prevalent, so there were abundant opportunities of proving the truth or otherwise of his assertion. So off we started for the ward and examined the chest of every child. He held his ground and was able to point out in every case I brought forward at any time, one, or more, patch of lobules into which no air entered, solid and hepatised.

METASTATIC PNEUMONIA.

Whilst speaking of pneumonia, I may, perhaps, be allowed to digress slightly. Elsewhere, in another hospital than Guy's, whilst I was temporarily in charge, there was admitted, about two years after the above event, a man whose intellect was slightly abnormal. I found him to be suffering from what was apparently lobar pneumonia. The solid portion was easily defined and distinct. There was a sharp contrast between the two areas, which I pointed out to the pupils, who in turn made a physical examination.

On our visit the next day, this dull, airless patch was resonant and normal, while another portion was affected. As far as I remember, one side alone was involved and the dull area was about several inches broad. I felt I had got hold of a case of "metastatic" pneumonia, and asked one of the Assistant Phy-

sicians who happened to be in the wards, to examine the case. He did so, and agreed that the patch was pneumonic. He also saw it with me the next day, when the patch had again shifted. It was not in any way just an extension or recession, it was an entirely new patch every time, in no way to be distinguished by its physical signs from an ordinary lobar pneumonia, and this, it must be remembered, was in the early seventies when acute lobar pneumonia was a very rare disease, and not to be confounded with the lobular or catarrhal variety. In fact it is the only case of metastatic pneumonia I have ever seen. I see in the "Guy's Directory" the name of at least one man who, as a student at the time, daily watched the case with interest.

To return to Guy's and the Evelina Hospital—during the first year or two of the journal's life, the late Sir James Goodhart had not long ago retired from his post there as House Surgeon. I knew him well as a young man and had frequently met him after he had left both Guy's and the Evelina. He had a very pleasant earnest face and there were but few of those who knew him who were not attached to him.

As I have said, the hospital was almost entirely supported by the Rothschilds, the founder especially taking a keen personal interest in the institution. Rothschild was very fond of Goodhart, and the friendship of such a man was a thing at that time for anyone to reckon with, but to a young man as Goodhart was then, it was a lever powerful enough to overcome any obstacle. He was indeed a friend worth having. I used to carry verbal invitations to dinner, which I often wished had included the messenger. Frequently after entertainments at his house the Baron would send down the broken pastry, of a suitable kind, to the Evelina for the children to eat.

It was an extraordinary fact and one which we could not have believed had we not seen it, that the majority of the children did not care for it, and I have frequently seen most delicious cakes, Madeira, sponge, etc., lying strewn about the floor of the wards, but they would eat with avidity the heavy, leaden boiled dough which their mothers surreptitiously smuggled into the wards.

I remember one pale sickly child whose temperature was a constant puzzle. It could not be got down to normal. It was at last noticed that it always ran up on the day following visiting day. The visiting friends denied bringing anything in unknown to or without the approval of the nurse, but still the pyrexia kept up. Search was made about the cot, but nothing was found, and both patient and parent denied the introduction of any food. But our wary H.S. by this time was fully aroused, and he determined to take sharper measures. So during the visit of the mother, the child, observed form a distance, was not observed to eat anything, and immediately the visitors had gone a descent was made on the cot, and there lying hidden deep among the bedclothes was found a "pudding" as heavy as lead. It would be difficult to conceive a more horrible-looking mass. It looked as though made of flour and suet and sugar, mixed and boiled together. It looked something like the "balm" or suet puddings which are eaten so universally in Sussex farmhouses, but instead of being light like them, it was solid and of great weight. Other cases I could quote on the same lines, where the lives of children have been nearly sacrificed by this same obstinate and misguided "kindness" on the part of relations and dear friends.

Clinical Thermometers.

I cannot say now what the date was when clinical thermometers were first made and introduced, but it is an event with which the names of Wunderlich and Clifford Allbutt are closely associated. My concern is the time when they were first introduced to Guy's Hospital. They began gradually to be used in the early seventies; they were not in general use—only a few had one, and when it seemed desirable a medical ward clerk would be asked to take a record of the temperature. I remember such a request being made as regards a case in Stephen Ward. The Gazette was about completing its first year. The clerk set out to find a thermometer. He heard that the H.P. had got one. He was given a silk-lined case containing two, one straight, the other curved at the bulb like a hockey stick. This was said to facilitate taking an axillary temperature. They were thick, clumsy, glass cylinders about six inches long. There was no index and they were invariably used in the axilla. They were placed in position by the arm being first extended while the bulb was accurately buried in the skin folds and then pressed by the operator over the front of the thorax and pressed close to the ribs or xiphoid. The arm movements were entirely passive, being

controlled by "taker" seizing the elbow and manipulating the humerus much in the same way as the older surgeons reduced dislocation at the shoulder joint. It was in those days it was a much more formal proceeding than now and was only occasionally required. The arm was held by the surgeon in this constrained position for five minutes, and as the early instruments had no index to remain in situ so that the recorded temperature could be read at any time, one had to try so to place the column of mercury that it could be easily seen, which was a difficult matter very often. Then the thermometer had to be bodily snatched from its place and read as quickly as possible. The column of mercury did not recede as quickly as it does now, for the bore and bulb were larger, the glass thicker, so that the heat was retained longer, but at first it was a clumsy and inaccurate process and at first was taken more to satisfy curiosity than anything else, for, as can be easily understood, we had no knowledge of the influence of disease on temperature. It had to be gained and formulated.

At first these large, heavy instruments were expensive, but their manufacture rapidly improved and an experience of their use grew and became more general and the time taken shorter. The stationary index was a great boon. I think it did more than anything else to make the employment of the thermometer universal. Other improvements followed, and as we began to understand the indications it afforded, and temperature taking was included in a nurse's duties, these former obstacles were soon forgotten. Looking back, I should say that when the GAZETTE first opened its leaves, in 1872, the clinical thermometer was regarded by the majority as a fad, useful, perhaps, now and then to say *how* hot a patient really was, but of no practical use or help in treatment. Every year that went by after that showed marked progress, so that in a very few years its use became a necessity and one of the most accurate and trustworthy guides the physician ever had.

OLD BUILDINGS.

I would like to describe the change which has taken place in the old public buildings around Guy's, but cannot very well do so without knowing which have been swept away, or have been altered, and which are the same now as then.

I have been told that the White Hart has been "renovated." In the sixties and early seventies it was the same as in Sam Weller's day, and it required no great stretch of imagination to people it with the immortals that went with Mr. Pickwick on his travels. Its stable yard was surrounded by the balustrades and wooden galleries which Dickens has immortalised. The Horsemonger Gaol was still standing, but no longer used as a debt prison. It was very near the White Hart, which was crowded about 1 p.m. with Guy's men eating their dinner.

The "Half Moon," a little lower down, was considered a little more select and was preferred by some, but it was not until I got a seat, on a very crowded occasion, in a position not usually open to diners, from which I could see the kitchen knaves and scullions and servants who were not in black coats and white ties, that I really had proof of what I so long had only suspected, that I finally bade the "White Hart" adieu and selected a cleaner hostelry.

The glamour of cherished associations and the halo with which the touch of Dickens seemed to surround all he touched, was not sufficient to check the anti-peristalsis and diaphragmatic movement of uneasiness provoked by the peep that day into the kitchen where the food was being handled and cooked.

Henceforth I much preferred those places in the City where succulent chops and steaks could be selected by each customer from the general array and cooked on the "silver grid" over a clear fire in the very room in which he ate it by a cook with clean hands and clothes of spotless white, holding in his hand a bright silver tongs with which he manipulated the dainty morsels.

OPERATING THEATRES.

In the days of which I am speaking, no sister or nurse was present in the theatre during an operation. All were rigidly excluded. The general body of students occupied the raised benches. The H.S. gave the anæsthetic and the dressers stood around; any of the Staff present sat on the horse-shoe seat running round the table. Millikin, the instrument maker, the forerunner of Down Bros., stood at the north-west corner, having charge of the instruments, whilst Monson Hills threaded all the needles with silk reduced to a fine point by means of his sticky saliva and grimy fingers.

One can see with eyes of memory the incongruity of an operation, say, of excision of the knee, being performed under clouds of spray and baths of carbolic acid, completed by sewing up with these septic sutures, and then carefully covered in and packed in a long box. Afterwards sutures and ligatures were "prepared" by being kept in jars of carbolic oil. What wonder that they often suppurated under these conditions? It is only when one sees the enormous difficulties and unrecognised errors, the pitfalls into which its devotees sank and were left to get out as best they could, by their own intelligence, that one can properly appreciate the patience and philosophical thought and logic of Lister in making his method perfect.

Such a vast amount of time was then wasted over useless formalities, and many absolute necessities had not yet been found out, that one wonders why the faithful band did not give up in despair disheartened and disappointed.

The most ardent follower Lister had in those days was one of the younger Assistant Surgeons who so firmly believed in the soundness of his master's views that he spared neither time nor trouble to win success. But the time was not ripe, the system was not perfect, so that all his toil and complicated ceremony was thrown away and wasted. Why? It would all be due, perhaps, to one septic ligature or suture because we had not yet fully mastered the simple way of sterilisation—a pair of clean hands. It was looked on as an insult to be told to wash one's hands properly. But if this simple stumbling block could have been got over and then the silk boiled for just five minutes, what years of trouble and anxiety might have been spared!

I remember a well-known Guy's man, whose likeness can be recognised in Bryant's textbook on Surgery, as taking part in an operation, made an appointment with me many years after Listerism was supposed to be fully understood and accepted by the whole surgical profession, to do an abdominal operation on one of his patients. On my arrival at the time specified I found a note asking me to wait as he was at a confinement. I waited, and in twenty minutes or so he drove up, took off his coat, rolled up his sleeves, and said, "I am ready." "No, that will not do," I said, and proceeded to get him in a fit state to assist, whilst my assistant and nurse saw to other things. He was quite his old gentle self, willing and obedient, until he came to the sterilisation of his hands. He objected to wash them again, for he said he had only just washed them and they were quite clean. I insisted, but his face became clouded at my imputation of his hands being dirty. He refused with rather a suggestion of anger. Had it not been that I had the advantage of a long experience of his sound good sense and feeling, I might have failed to induce him to comply with my request, but I hinted that probably mine would be none the worse for another scrubbing, and soaping, and he merrily agreed to keep me company, and happily our efforts were crowned with success; but this will show the hard work Lister had to get some people to see the rationale and spirit of his views. Like the Jews of old, they could see only the letter and the ceremony; to teach or try to teach was to insult.

It was not without its humorous side, however. Mr. Howse was once going to open a urethral abscess in the theatre. It was an extensive one, thoroughly ripe, and I remembered the penetrating stench of the pus. He was an ardent Listerian, and as I had been his dresser, I made bold to ask him if he would object to me starting the carbolic spray. "Not at all," he answered, laughing; and, turning round to the group of dressers, continued with great glee, "The House Surgeon wishes me to perform the operation antiseptically. Ha, ha, ha!" I enjoyed the situation as much as he did, but from another standpoint. As soon as he plunged his knife into the bag of pus, the stench was so strong as nearly to knock him backwards; he jumped up, and, rapidly pushing his stool away, called out, "Start another spray; start it at once. Ugh! pooh! What a stink." I thought I had scored rather. It was not that I knew more than he did; but we had had a similar case a few days before, which had nearly poisoned us all, but he was not present, and he had forgotten.

The enormous field which the discoveries of Lister have opened up for the relief of the sufferings of humanity, may be seen in the fact that 50 years ago in Guy's there was one operating theatre only. One afternoon a week sufficed for the full staff to get through all their work, except on some exceptionally busy weeks, when the theatre was again used on Friday afternoon.

What time is filled at Guy's to-day by major surgical work I have no knowledge, but it must be many times larger than then, for at a very much smaller hospital with which I am accurately acquainted, there are two theatres which are sometimes busy the whole week. It is necessarily so, for to-day if any surgeon looks through his list of operations he finds the majority of them such as would have been impossible during the septic days.

I saw more recently than these early times rather an unusual sight once in an operating theatre. Duty called me once to Fort Elizabeth, South Africa, to the home of one of the surgeons to the hospital there. Incidentally I walked over the wards, and was amused at the arrangements made for "Black and White." As he had an operation to perform, I waited and looked on. I was handed a cigar box and took a cigar in my hand. The case was evidently a pyæmic abscess in the pelvis, the temperature indicating an undrained collection of pus. He paused with the knife in his hand and said he was waiting until I lighted up. "Oh, I couldn't think of smoking in an operating theatre," I said, "it would be sacrilege." "Nothing of the sort" he replied, "we always do." This was confirmed by the others present so I proceeded to do so, and lucky too that I did, for the odour was poisonous; but this is the only instance I have met where it was a recognised custom to smoke in a modern operating theatre. I cannot say it commended itself to me, although in the present instance it was salutary. It was not because the staff were of slovenly habits, the one of whom I speak, the only one I knew, was a most able surgeon. He has been dead many years.

The Hop Industry.

I can never forget the awful sight about the year '73, when the large block of hop warehouses in Maze Pond were burnt down. They were for the most part full of hops and as the fire got hold and the roofs fell in, they looked like one huge solid mass of red hot coke. We got on the edge of the roof of the Medical Wards and then looked directly down into the burning mass. The heat was intense. All the narrow streets around were filled with fire engines, ladders, escapes, etc. Every possible advantage was made use of to subdue the flames, but to us taking a bird's eye view of the whole area, it seemed as if the streams of water from the fire-hose were no bigger than would be from small glass squirts and served more to augment the blaze than diminish it by washing off the burnt ashes and so making room for air.

The heat was intense. It cracked the glass of the hospital windows and the beds of the patients had to be removed to the other side. The impossibility of extinguishing the fire was evident and all efforts were turned to limiting the extent of it. How small the men looked the ground! What pigmies they seemed and how slight their efforts when compared with this fierce tempest of fire! We were so engrossed in looking down into this wonderful sight, that we had not noticed that the only barrier which stood between us and a fall from that great height to the ground was the coping of ornamental cast-iron work which decorates the top of the building where the slope of the roof meets the wall. No sooner did we realise the strain which this crowd was putting on what was merely an ornament, than the majority realised their own danger, and warning those who remained, took up other positions, but I distinctly remember that my opinion at the time was, that had not that slight coping of cast-ironwork been much more strongly secured than is usual, well nigh a hundred men would have been flung to the ground.

As Guy's stands in the middle of the London Hop Market, it may interest some of the readers of this if I ask their indulgence to follow the trail of this hop fire into paths which affect our own personal life and comfort.

Not long after this I lodged at the house of an employee of one of the very large brewery firms whose names are so freely displayed about the streets of London. I asked him if this fire would at all affect the supply of hops or cause other difficulty in the brewing industry. "Not the slightest," he said, "In fact, I might say, it would make no difference to us if there was never another hop grown." He went on to explain the reason, which is much too long for insertion here, but it was brought back to my mind years afterwards by the following:—

A case of torticollis took me to the daughter of a man who kept a public-house in a side street of an industrial suburb. The parents were certainly a steady couple, but I was astonished to find that they were making a large income and were the owners of much real estate. The daughters also were being edu-

cated at most expensive schools, and money in no way spared where their welfare and comfort was at stake. On my expressing surprise that so much could be made out of an apparently small public-house in an unfrequented street, I was told that it did an enormous trade, not only on the premises, but in barrels of "home brewed," as it had the reputation amongst the surrounding population (who relied on the assertion of the proprietor), that its ale and beer was brewed exclusively from malt and hops, and this could be proved on all brewing days by sight and smell of the spent malt which had been used. These "grains," as they were called, were generally being taken from the vats and carted away at the time that the street was flooded by workmen leaving their work.

A year or more after this an emergency case called me at dawn one morning to the same district. As I passed this public-house it was just light enough to see plainly, but the street was still and deserted. At the gates of the brewhouse yard stood a large dray which was being rapidly emptied of little square compressed bags, which I readily recognised by their appearance, as well as the faint blue letters stamped on them, as "glucose." The quantity seemed enough to last for many brewings and probably came from a distant quarter, so that it is questionable if there was anyone else than the owner ever aware of its arrival and even then its use may not have been suspected. Here, then, was the secret of "Pure Beer brewed from malt and hops only." Since then I have met with two exactly similar cases, where large incomes were made from successful exploiting.

Some years afterwards I was staying at an hotel in an attractive part of the country and made the acquaintance of the owner of the large brewery in the district. He used to come in to lunch every day and always sat next to me. One day, as we were talking, a friend of mine came up and said that they were thinking of taking a drive the next day to a certain historic place at a distance, asking if I would make one of the party. I consented and my brewer acquaintance, whose house was a few miles off in the country said, "I know the place well and would like to go with you if I might be admitted." Room was found for him and he went. When we were about half way there the sky became very black and there was every appearance of a storm. It was decided to put up, until it passed over, at a little country hotel which we were approaching. I observed the walls of the entrance hall of this comfortable looking hostelry to be hung with coloured lithographs relating to the brewery of my companion. "Yes," he said, "this house belongs to us." "Then let us," I replied, "drink each other's health in a flagon of your own particular brewing." "I shall have great pleasure in paying for the drinks," he said, "and sending some out to the coach, but I will not drink any." "Are you an abstainer?" I enquired. "By no means, but I will not take any beer," he persisted. I tried to induce him, thinking his reason perhaps lay in his not caring to appear as a prompter for the sale of his own goods. It was useless, and at last he said: "My friend you are evidently not a man of business or you would understand, I am a brewer, and I brew to sell not to drink." "So I suppose," I added, "but I don't ask you to drink a barrel, and a glass will not hurt you, unless" I added as a satirical joke, "you put a lot of arsenic into it." Guess my astonishment to hear him say, "As I said, you evidently do not understand business, but if it paid us to do so and it did not spoil the appearance or taste of the beer, and the public, we thought, would not find it out, we would brew from, (here he glanced at the road) worse muck."

To say I was astonished would ill express my feelings. He smiled as he saw my surprise and said, "Now you will understand," I am afraid he was speaking only too truthfully, for it has been more or less confirmed by many little incidents which I have noticed, but which might have passed unnoticed had my attention not been sharpened.

My experience has been severely criticised and declared to be "unreliable," "exceptional," "unusual" and a host of other adjectives, but the facts are as I have stated them. I am quite prepared to admit that they may be pure coincidences and unsupported by the experience of others, but I am not prepared to have them denied or even doubted. I am a moderate drinker but not a total abstainer, but if brewers and others engaged in the liquor trade wish to gain my approval they must make it a rule to do what is well within their power, and what every honest man would do only, and that is put only on the market such products as they know are not only harmless, but also are beneficial and such as they would

willingly themselves drink. Which is, I take it, from a brewer's point of view, only another way of expressing the rule which always guides the words and actions of a Christian gentleman, to do to others as he would they should do to him.

Here my memories of the infancy of the GAZETTE must be brought to a close. Most of the actors in the scenes depicted are now retired from the stage. But few of my old friends are left, and of these I am proud to say that throughout our long lives our friendship has remained unbroken, and time has verified what their youth foretold, that the name of Guy's man has been, as may it ever be, like the leopard's head on my teaspoon, a hall mark which declares the high standard of the bearer's character to all the world.

THE END.

Reviews.

Text-book of the Practice of Medicine. Edited by F. W. Price, M.D., F.R.S. (Edin.). Published by Messrs. Henry Frowde and Hodder and Stoughton, London, 1922. Price 35s. net.

The publication of this work still further increases the difficulty encountered by the present-day medical student in deciding what text-book of medicine he is to purchase. Five years ago Osler practically held the field. Only this year a formidable rival appeared in the new edition of Taylor's Medicine, revised by Poulton, and now we have to welcome a completely new text-book, which is the result of no less than 27 contributors. Among these there are four representatives of the Guy's Staff, namely, Sir Maurice Craig, Dr. A. F. Hurst, Dr. M. S. Pembrey and Mr. E. G. Slesinger.

The present work carries one step further the tendency for the larger text-books to become the composite work of a number of authors, instead of being the result of one physician's clinical experience. This is bound to be the natural result of the great expansion in medical science. At the present day it is practically impossible for any one man to write with authority on all the subjects which clamour for admission to a text-book of medicine.

Yet, though something may be gained by the employment of many authors, in so far as each subject tends to be dealt with by a specialist, we cannot be blind to the fact that a book which is so produced lacks the cohesion and balance of the earlier works by a single author. The personal element, which is so great a point in such books as Osler, or still more the first edition of Fagge's Medicine, can never be obtained in such a book as that under review. If it be granted that a text-book must be written by a large number of authors it should be the function of the editor, as far as possible, to maintain some sort of balance in the work. We cannot congratulate Dr. Price on his success from this point of view. For instance, if we look up the article on Pernicious Anæmia we find little over two pages, whereas over eight pages are devoted to Subacute Combined Degeneration of the spinal cord. Again, in the article on Pernicious Anæmia there is no mention of the absence of hydrochloric acid in the gastric juice, while in another section of the book another author expresses the opinion that the gastric achylia is the fundamental fact in the disease. Or, as another example of lack of proportion, we find an article of nearly twenty pages dealing with metazoan parasites, which gives full details of many parasites whose names we fear might baffle many of the examiners in the College of Physicians, to say nothing of the examinees.

It is naturally impossible within the compass of a review to attempt a criticism of more than a few articles. One most striking omission is the subject of tuberculous kidney. In the whole of the section on Diseases of the Kidneys, some 60 pages in length, we can find no mention of tuberculous kidney, except in two lines under Hæmaturia. It is, indeed, astounding that such a grave omission should have passed unnoticed either by the authors of the section in question or by the editor.

Another rather striking omission is in the sections on Auricular Fibrillation and Flutter. There is no mention of the recent work of Lewis on these subjects.

On the whole, most of the articles tend to be too long rather than too short, and often, we fear, it will be difficult for a student to see the wood for the trees. As an example, in the article on Small-Pox the symptoms of pain in the back and vomiting are mentioned, but only along with a host of other symptoms common to every severe infection. On the question of Liver Abscess and Amœbic Hepatitis no stress is laid on the frequency and importance of a right basal pneumonia as an early and sometimes only sign.

We are disappointed in the section dealing with the investigation of the gastric functions by means of the fractional test meal. Although the method is explained at some length, no examples are given of the types of curve found commonly in certain pathological conditions such as duodenal ulcer. With reference to the subject of occult blood in stools there is no mention of spectroscopic examination of the extract.

On the subject of rheumatoid arthritis or non-specific infective arthritis, as the author prefers to

call it, much stress is laid on the importance of focal sepsis and its removal. For the acute stages of the disease complete rest of the affected joints is advised, but there is no caution about the maintenance of the joints in a satisfactory position. How often this is neglected is only too obvious to anyone familiar with the chronic types of rheumatoid arthritis. Nor, we think, is sufficient stress laid on the enormous improvement in function that may be brought about by adequate orthopædic treatment.

The book is convenient in size in spite of the fact that it contains far more letterpress than any of the other standard one-volume text-books on medicine. This is due to the fact that it is printed on paper which, though extremely thin, is both tough and opaque. Unfortunately the type is set rather too close up to the inner margins of the pages for comfortable reading.

Rugby.

GUY'S v. BRISTOL.

The Bristol team crossed our line at Bristol on October 21st three times to our twice, and are thus entitled to their victory, though only the difference of two points divided the scores in the end. Bristol gained 2 goals and 1 try (13 points), Guy's 1 goal and 1 penalty goal and 1 try (11 points).

It was a rattling good game between two most evenly matched fifteens. Bristol had two good men away in Pickles and Spoors, and we had to do without the services of Albertijn, Steyn and Duncan.

Guy's were the first to score, and it came about quite soon after the start—a typical Guy's movement, the ball well handled, and Van Schalkwijk cut through magnificently to hand on to Hirschberg to score a very fine try indeed. Van Schalkwijk added the extra points. Corbett, of Bristol, had a drop at goal. Unsuccessful at this, a hot pressure was put on our line, which Daneel did well to keep from being crossed. He was aided in this defence by Bekker and Mostert. However, Bristol would not be denied, Budd gaining a try and increasing the points to five with his effort to goal. Before the interval Guy's got their penalty, Neser successfully negotiating a penalty kick.

The second half was not quite so much in our favour; anyhow, Bristol seemed to see more of the ball. Perhaps Zondagh's absence affected our halves getting the ball from the scrum as freely as usual. Bristol put on a couple of tries, Hore scoring and Budd converting; the second try came from Coventry. The home full back really started the movement by running up-field instead of putting in the orthodox kick. Bristol now led by 13 points to our 8. A try gained must be converted to draw. The Hospital men set about it splendidly; great was the excitement as Bekker was dragged or "barged" himself over for a try. Carefully did Neser take aim, but good as was his effort, the conversion just failed. Not done with, Guy's came again and yet again, in the few remaining minutes; though often near, and once or twice within an ace of more points, no success attended the magnificent effort of the Hospital XV. to win the match. All played exceedingly well, and to criticise when all tried so hard would appear ungrateful. Final score as above.

Team.—S. H. Daneel, A. Hirschberg, J. G. Van Schalkwijk, G. R. Mostert, R. Fellowes-Smith, F. Bekker, E. L. Sprong, W. D. Doherty, W. H. Taylor, E. E. Neser, B. G. Scholefield, F. J. Biddle, N. M. Holloway, F. G. Hutchinson, J. W. Schabort.

GUY'S v. HARLEQUINS.

A splendid crowd assembled at the Hospital ground on October 28th to witness what proved to be a very hard and gruelling match, fought out without quarter and without complaint.

Mr. H. B. Cotter refereed, and all Rugby men know his excellence. The game was commenced punctually. At once Guy's attacked and ere many minutes we were well in Quin's "25." Sturdily Wakelam and his forwards got a move on and to half way we returned. Here the ball got loosed and Gracie moved well up field. Later he got B. L. Jacot away, who ran by our field till touch stopped him. One back and two forwards I would commend for their defence; the rest went down fearlessly enough, but they seldom stopped the man who ran with ball. Delightful work by Albertijn and Steyn, a cross-kick by the former, and Scholefield scored for Steyn to convert. The kicking was remarkably good, and the way the forwards heeled very fine. Sprong passes too often standing still. It was not Bekker's fault that the three's were not off the mark more quickly. He whipped the ball out in his best style. Bekker had got his opponent well "set" quite early, and played his best game, how good that is we all know.

Resuming, some passing looked like bringing a score; Scholefield and Neser were in the movement (these two forwards were in excellent fettle); nothing resulted; then Albertijn tried a drop. Steyn, by dashing back, prevented Wakelam scoring. Now came a lucky score for us, Steyn dropping at goal from a penalty, and the ball rebounding from a Quin. Guy's picked up and Albertijn receiving dashed for the line to touch down, Steyn again kicking a goal. The Harlequins had not been quiescent all this time. One must say that their passing was not very accurate; great speed was in their threequarter line. Jacot on one wing showed much force. Gracie, the Scotch International, was ever in the picture, though closely marked. On the left wing was J. C. Gibbs who had so few chances, but he is a player who will probably figure among the many notorious Harlequin threequarters. Just before no side, Gracie followed

up a high punt, and beating Daneel, Marshall got a try, owing entirely to Gracie's great speed and persistence. It was anything he would not catch Daneel before he cleared, but he did, and Marshall's try being converted by King, a really fine game ended. Guy's 2 goals (10 points); Quin.'s 5 points.

Team.—S. H. Daneel, A. Hirschberg, C. L. Steyn, P. K. Albertijn, G. R. Mostert, E. L. Sprong, F. Bekker, W. D. Doherty, W. H. Taylor, E. E. Neser, B. G. Scholefield, N. M. Holloway, F. G. Hutchinson, E. F. Fouraker, J. W. Schabort.

GUY'S v. BLACKHEATH.

A record crowd gathered at Honor Oak Park on Saturday, November 4th, for this popular fixture and they were rewarded with a great display of Rugby Football. R. F. H. Duncan could not play; his leg was again damaged at Richmond on the previous Thursday, and he is now receiving surgical attention. All will wish him a speedy recovery and a quick return to the XV.

Packed everywhere, the stands all full, the teams turned out punctually to decide the issue of the day on the Hospital ground, on which every effort had been made to provide accommodation, and the setting was worthy of the encounter. The turf was slippery after the deluge of the night before and this naturally affected foothold, but Guy's have never handled a dry ball better, and this particular match was played out with the leather as greasy and difficult to hold as can be imagined. We had the advantage of wind and sun to start with, and very soon Sprong and Albertijn set up an attack. Fouraker showed up well and Blackheath were hard put to it to defend. At full back they had Forsayth of Oxford and Scotland, and he was truly magnificent; more and more as the game proceeded had Blackheath cause to be grateful to the International's splendid full back play. Steyn cross kicked, but the high wind carried the ball dead. Soon, however, Sprong picked up, and, slipping through in his most elusive style grounded for a try. Neser kicked excellently, but unsuccessfully. Strong, of Blackheath, intercepted, but his wingman failed to gather, and Blackheath soon after had a pot at goal from a penalty. Forsayth conceded a minor with Scholefield close on to him. Albertijn next was stopped inches out. But Guy's were now pressing severely, and the movement, a forward one, ended by Fouraker scoring very far from the posts. Just before the interval Albertijn just failed to drop a goal.

The game restarted. Blackheath failed to take advantage of a penalty against us. Grandly the Hospital men were playing now, a team of 15 men playing together with understanding. Neser was filling the position of rover, and his activity and spoiling were of great advantage. Forsayth got Mostert when almost a scorer. Albertijn sold his favourite commodity with ease, but not much success. Blackheath could defend, though their attack, except for one or two rushes, was not very much in evidence. Just before the end, James, a Blackheath half, put his knee out, and took no further part in the game. The closing stages were remarkable in that Guy's attacked so often and pressed so hard, yet they could not penetrate again the rock-line defence which Forsayth and his fellow defenders put up against us. C. W. Lowe, the English International, was on Blackheath's right wing, but seldom did the ball reach him, and his opportunities were those of chance and not of thought-out endeavour. Guy's have never done better. One would like to see Daneel a little quicker and a little more certain, but his effort must not be compared with Forsayth's, who at the present moment has probably no peer in the four countries. A little more hearty in the tackle, a little more ginger in the loose, and Guy's will have trained on to that greatness which some good friends kindly said earlier in the season we might attain. Guy's 2 tries (6 points); Blackheath nil.

Team.—S. H. Daneel, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, G. R. Mostert, E. L. Sprong, F. Bekker, W. D. Doherty, W. H. Taylor, E. E. Neser, E. H. Fouraker, B. G. Scholefield, F. G. Hutchinson, N. M. Holloway, J. H. Schabort.

Hockey.

GUY'S v. WALLINGTON.

The Hospital suffered their first defeat of the season when they were defeated by Wallington by three goals to one.

The game was chiefly characterised by the admirable play of the Wallington forwards. The Hospital forwards still continue to vitiate their efforts by failing to put into action two of the essential rudiments of forward play: firstly, that the ball must be centred into the back of the circle and not into the goal mouth; secondly, that a forward must go straight and pass and not run round the defence, which entails the defenders falling back into the base of the wedge, thereby inserting at least three men between the ball and the man to whom it is eventually centred.

Owen played well at outside left, Hooper and Kempe at half, the latter being especially good. Schollum scored for Guy's with an excellent shot.

Team.—Reynolds, Bowen, Graham-Bonnalie, Kempe, Hooper, Gathergood, Housden, Kingsbury, Schollum, Pidgeon, Owen.

Papers by Guy's Men.

Sir Maurice Craig, C.B.E., M.D. Mental Symptoms in Physical Disease. An abridgment of the Bradshaw Lecture before the Royal College of Physicians of London.—*B.M.J.*, 1922, ii., 841.

Birth.

GIBBINGS.—On October 7th, 1922, at Cape Avenue, Salisbury, Rhodesia, the wife of R. G. Gibbings, L.D.S., a son.

Death.

THORNELY.—On October 30th, 1922, at 21, Alexandra Road, Epsom, Michael Harris Thornely, F.R.C.S.E., M.R.C.S., L.R.C.P., O.T.M., Lt.-Col. I.M.S., aged 47 years.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

A fortnight ago, on Armistice Day, in the presence of an assembly of Guy's men and women, the Superintendent hung a laurel wreath, tied with the Guy's colours, upon the Memorial Arch, the Chaplain read from the Apocrypha the passage which includes the words carved upon our Memorial, buglers sounded the Last Post, and two minutes' silence were observed.

There is a general feeling that this corporate act is an appropriate way of expressing our homage to those who gave their lives during the War, the ceremony providing a fitting setting for the observance at Guy's of the universal silence. A more detailed account is published on a later page.

THE sight of children in Maze Pond, surrounding every available "doctor" and making what may appear, to him, an absolutely unintelligible request, reminds us that we are once more drawing near to the close of the year (more briefly, that Christmas is coming). Very few students have not been at some time or other asked by an incredibly grimy child (in whom it is hard to recognise the incredibly clean child of Sundays and Christmas), to "put me down for the Christmas Tea, doctor."

Children who are attending Out-Patients or who have done so during the year, are admitted on Christmas Day to a feast which the Landon Out-Patients' Tea Fund provides, and are there given the time of their little lives. Not only is a tea provided, but there is also a Christmas Tree, and each child is given a present before departing. The number of children is necessarily limited to about 700, hence the anxiety of those who fear that they may be too late to be "put down."

The Niggers visit the children while they are at Tea, and are generally accorded a reception which, if it makes their voices inaudible, at least is not lacking in enthusiasm.

We feel sure that anyone who has but once seen the children enjoying themselves will do his best by adding his quota to contribute to their pleasure. None of the many tolls upon a man's pocket which Christmas exacts should be paid more willingly.

Those who wish to help, whether by sending money, or by giving dolls or toys for the Christmas Tree, should send their contributions to Sister Out-Patients.

We publish on page 483 a letter from Dr. Campbell, together with one from the Chief Organiser of the "Save the Children" Fund, both containing an appeal to Guy's men to contribute a further £50 in order to complete the funds necessary to open a Guy's Hospital Kitchen in the Famine District of Saratov in Russia. Dr. Campbell points out that although the recent harvest has eliminated the necessity of providing for adults, the children are still in urgent need of help. The comparatively small sum of one hundred pounds would provide for a kitchen which, carefully managed, would be instrumental in saving the lives of many children. Some economists would have us believe that charity should end, as it begins, at home. But, even apart from higher ethical considerations, it is obvious that in caring for starving children in Russia, British contributors are performing a task which reacts favourably not only on Russia, but on the whole of Europe. Bolshevism feeds on famine, and although we are assured by newspapers that its hold upon Russia is slackening, it cannot be cast out until there is a population virile enough to do so. When Russia is healthy, she will emerge by her own efforts from the slough.

Medical men must always be gratified when they are represented in Parliament by a member of their own profession. We should like to see in the future an even greater number of medical men in the Commons. They are at any rate better fitted than the majority of their fellows in the House to express an opinion upon most of the really vital national questions, even though their legal confrères may be more experienced in such matters as the framing of a bill, the wording of a statute, or other necessary administrative work.

We offer our hearty congratulations to Lieut.-Colonel F. E. Fremantle, who has retained his seat as Unionist Member for the St. Albans Division of Hertford, and to Dr. Salter, the Bermondsey Labour Candidate. Both are Guy's men.

As regards the question of Medical M.P.'s who are members of the Labour Party, we must confess to a certain satisfaction at their election. However strongly we may disagree with the Labour Party's programme, we must admit that the effectiveness of a legislative assembly lies not only in a balance of parties, but also to no small extent in the individual characters of its members.

We are sure that the doctors will exercise a salutary influence.

Those interested in permutations and combinations and those who fancy themselves as judges of the tastes of the public will find an ample opportunity for the exercise of their talents in the Great Hospitals' Judging Contest, advertisements of which are to be seen everywhere. The object of the competition is to complete as rapidly as possible the total of £500,000 for which the Prince of Wales asked in his Appeal. This sum, urgently required to clear the hospitals of debt, has not yet been reached, and it is to be hoped that the competition, which has been made possible by the generous contribution of £11,000 to the Prize Fund by ten well-known firms, will reward its energetic organisers with really good results.

We have no doubt that quite a number of Guy's men have already entered for the competition. It should prove amusing.

We trust that it will meet with the success it deserves.

We congratulate Mr. A. H. Douthwaite upon obtaining the M.R.C.P., Mr. G. W. Heckles on obtaining distinctions in Surgery in the recent M.B. Examination, and the other successful candidates whose names appear in the Pass Lists in this issue.

We publish in our correspondence columns a letter from Miss Paterson, whose interest in ante-natal and post-natal hygiene and Infant Welfare work has already been expressed in a letter to the Gazette some time ago, and who trained under Dr. Truby King, and has been, since leaving Guy's, associated with him in his work. The extent of the Government campaign in New Zealand is, perhaps, not always fully realised at Guy's, but there can be no doubt that the Plunket Society and Dr. Truby King have performed, and are performing, work of the highest importance to New Zealand and to the world at large. We have commented before, in these columns, upon the work of the Plunket Society, and it is good to hear that there is no abatement in the intensity of the campaign.

Dr. King's work has, perhaps, been better known since his visit to this country, and the most recent text-books of midwifery now contain references to his methods. Complete success comes to no one at once, and in an educative campaign in favour of certain methods of care of mothers and infants, time is bound to elapse before full results are attained. In the meantime Dr. King and Miss Paterson are carrying on the good work.

Armistice Day.

The Two Minutes' Silence on Armistice Day was observed this year at the Memorial Arch, and it is hoped that this may become our annual custom. In the presence of a large assembly, representative of all departments in the Hospital, the Superintendent, after briefly explaining to "Students, Sisters, Nurses and fellow-workers at Guy's Hospital" the purpose of the gathering, hung a laurel wreath tied with the Guy's colours on the Arch. The passage from Ecclesiasticus XLIV. which incorporates the motto "Their name liveth for evermore," (chosen at Mr. Rudyard Kipling's suggestion for all military cemeteries, and carved on our Memorial) was then read by the Chaplain, and the "Last Post" was sounded by buglers of the Coldstream Guards, who were on duty at our Memorial Arch by kind permission of the Commanding Officer of the battalion at the Tower. The maroons were heard at the conclusion of this, and the two minutes' silence followed. The ceremony ended with the Reveillé, again sounded by the buglers.

The opinion has been universally expressed that this method of commemorating the fallen and observing the two minutes' silence is much more impressive and appropriate than the isolated and individual stoppage of work all over the Hospital. There are two great advantages in a brief ceremony at the Memorial Arch. It provides a framework in which the two minutes' silence can be enshrined, and it collects everyone off duty and everyone on duty who can be released for five minutes in a *corporate* act of homage. Those who laid down their lives did so for us all, and it is as a community, rather than as individuals that we should make our annual commemoration of their Sacrifice. Their names, "living for evermore," inspire us to uphold the great traditions for which they died:—

"To you from flaming hands we throw the torch;
Be yours to hold it high!
If ye break faith with us who die,
We shall not sleep, though poppies grow
In Flanders fields."

As Sir Arbuthnot Lane said to us the other day: "The future is in your hands; you must make good." Armistice Day at the Memorial Arch should stimulate us to that resolution. For—

"All that they had they gave, they gave
In sure and single faith;
There can no knowledge reach their grave
To make them grudge their death,
Save only if they understood
That, after all was done,
We they redeemed denied their blood
And mocked the gains it won."

But "Their name liveth for evermore," and that shall never be.

The Physical Society.

On November 8th, in the Anatomical Theatre, the Society had the pleasure of hearing an exceedingly interesting lecture, on Lord Lister, by Dr. J. Rudd Leeson, who was at one time his House Surgeon. It was indeed a pleasure and a privilege to hear a lecture upon so great a man delivered with such earnestness and sincerity. One could well see the greatness of Lord Lister's character reflected in the reverence with which Dr. Leeson dealt with his subject.

Sir Arbuthnot Lane in introducing Dr. Leeson reminded the Society of the fact that following Lister's teaching it was the students who first introduced overalls into the theatres of this hospital, and who even provided overalls for the surgeons themselves. In this way, he said, the students educated the staff and in such manner does education progress, for teachers of themselves are apt to become dogmatic. He thought that were students taught logic and mechanics they would derive much more benefit than they did from the present first year curriculum. He thought that perhaps the capacity to forget was probably man's greatest faculty.

Dr. Leeson on rising said that he was very pleased to see the nurses present, for he could recall that in Lister's day there were heated arguments regarding the entrance of women into the profession, and could remember Lister saying that he would be sorry for the women if they could not do better than some of the men. He said that Lister had done more for humanity than any other man; for the conditions before Lister's methods were adopted almost beggared description. In the pre-Listerian days pyæmia was endemic in this and other hospitals, septicæmia was common and to be expected, and was even regarded as a healthy reaction; gangrene was an appalling calamity, the smallest of wounds frequently leading to a man's death. Puerperal fever was rife, a Lambeth lying-in hospital at one time closing its doors when the death-rate had reached 25 per cent. Ovariotomy was considered a terrible operation, the death-rate at one period reaching as high as 95 per cent. He could remember notices being posted advocating that the operation should be made illegal. As an instance of the crudity of the methods employed he told a story of a certain surgeon's coat, which when it had seen much hard service, was worn by the surgeon when he dissected; when it became too bad for this it was delegated to the post-mortem room, whence after a period of service it found its way to the operating theatre and was used by the house-surgeon whilst assisting at operations; and he could well remember the house-surgeon sticking eight or more of his already threaded needles into the lapel of the coat. Yet another story of a sponge called the "hospital sponge," which was used without any attempt at sterilisation between times, for swabbing various patients' ulcers.

He could remember one of the sisters once saying to him that she did not think the physicians could do any good, and that the surgeons did as much harm as they did good. Hospitals were in those days "whited sepulchres"; pus was so common that little was thought of it and was looked upon in the light of a London fog, as unpleasant but inevitable. The cause of sepsis was unknown; puerperal fever was variously ascribed to the patient's temperament, chills, visitors seeing the patient too soon, the onset of lactation, to sewer gas and lastly to the buildings themselves. To the discredit of St. Thomas' and the London Hospital, be it said that they had tried antiseptics and had abandoned them.

Lord Lister he described as having a beautiful but sad face; as one who never joked and who was never seen unless wearing a frock coat. He was a man of strong physique and a Quaker. He was a Yorkshireman, somewhat unapproachable, not considered particularly clever, but deeply sympathetic and of magnetic influence. Lister thought that a doctor should be a sort of superman and have the best possible education; for this reason he spent three years taking his B.A. He was a great believer in Pasteur, who had discovered that fermentation was due to organisms; and it was this fact that Lister for ever kept before him; a fact which in these days is a truism, but was in those days considered a wonderful discovery. One night on which Lister was making vain efforts to get to sleep, it suddenly struck him that gangrene might be due to a fungus, and so at 3 a.m., hurriedly dressing, he went down to the ward and removed some pus from a gangrenous wound and examined it under a microscope, but found nothing (one drop of methyline blue might have advanced antisepsis by ten or fifteen years). Why was it that a simple fracture, which the porter, or first dresser, or at any rate a sister could attend to, was so different from the smallest compound fracture, which might necessitate amputation? It was at that time thought that sepsis was due to the entry of air into the tissues, but Lister held that it was not the air but something in it which was the cause. To prove this he at one time carried about with him three flasks containing urine; the first without a cork, which putrified in a day, the second with a cork pierced by a small glass rod, which did not ferment for two weeks, and the third, with cork pierced by a long convoluted tube, this specimen remained sweet for at any rate fifteen years; all three having been previously boiled. Lister, following the teaching of Sharpey and Walter Hood,

believed that physiology was as much the key to surgery as it was to medicine.

In his earlier days he went to Edinburgh and became House Surgeon to Syme, from whom he learnt much practical surgery. He married Syme's daughter and with her a dowry of £100,000. Lister would never have earned his salt out of medicine and when he died his wife's money and the money he inherited from his father, a wine merchant, was considerably reduced. To him the idea of earning money by tending the sick and maimed was repellent and he used to implore anyone who was thinking of growing wealthy out of medicine to leave the ranks of the profession and join some third-rate trade. Dr. Leeson said he thought that it was a pity that a profession, out of which so much pleasure and satisfaction could be obtained when rightly practised, should for the last fifty years have become more and more mercenary and that he thought it was difficult for an honest man to make more than a bare living out of medicine. That if the practice of medicine brought a man a small bank balance below, it brought him great treasure above. One of Lister's favourite aphorisms was, "Do as you would be done by."

From Edinburgh Lister went to Glasgow, where at that time the populace was suffering much unpleasantness from the stench of the sewage which was run into tanks not far out of the town. For this German creosote was used with much success, and it was a spark of genius on the part of Lister that made him realise that if the creosote would prevent the fermentation of the sewage it would prevent fermentation in a wound. Consequently, to the next compound fracture that was admitted he applied what is believed to be the first antiseptic dressing recorded in medicine. It consisted of equal parts of creosote and plaster of Paris rubbed into the wound, which was then covered with tinfoil. It proved a brilliant success.

Lister, like Socrates, was a great teacher, but a poor writer. In his earlier days Lister never thought of washing his hands prior to operating, and never took off his coat, merely rolling up his sleeves and buttoning up the collar of his coat. He was one of the first to use a drainage tube and advocated that there should be no tension in a wound; and maintained that the comfort of the patient went far in producing a successful issue. He was much respected by the students, who at that time were a rowdy lot, and at his lectures there was always absolute silence, except on one occasion when one ribald youth at the top of the theatre greeted his entrance by exclaiming "Let us spray," for which he was summarily ejected. Lister hated and loathed examinations and rather regarded them as soul-destroying institutions, maintaining that a man's duty towards his patients should be a sufficient stimulus to work.

Anæsthetics, which in his day were in their earliest infancy, were regarded as somewhat old-womanish. His maxim regarding them was "the best chloroform and plenty of it." Woe betide the clerk who felt the patient's pulse; he would depend upon no sign except the breathing. He was wont to say that the two most useful drugs were rhubarb and soda. He was the originator of boracic ointment; and to Dr. Leeson fell the lot of being the first man to use it.

Lister indulged in many aphorisms, among which may be mentioned—

"Success depends upon attention to detail."

"Treat every patient as though he were the Prince of Wales."

"If you are not prepared to do this leave our sacred profession and go into some trade."

"What can we do for this poor man."

"Never ask a patient if he has had syphilis, if you know your work there is no need to."

"Never mention scrofula."

"Sepsis is a question of dosage."

In speaking of vivisection, he said that there was more cruelty committed in an afternoon on a gentleman's shoot than in a month on the dissecting room table.

A successful doctor required a liberal education, earnestness of purpose and sympathy. "Great as was the head, the heart was greater."

Sir Arbuthnot Lane proposed a vote of thanks to Dr. Leeson, which was seconded by Dr. Campbell.

Dental Society.

The opening meeting of the session was held in the College Smoking Room on Thursday, October 19th, over 60 members welcoming Mr. Lewin Payne on his third election to the President's Chair. The President's address was characteristic in temper and disposition of Guy's best traditions, and was of real practical service to new men and a stimulus to those who by now have qualified. Mr. Nicolai then read a paper, "Oral Sepsis," which paper has been awarded the Newland Pedley Gold Medal.

The degree of attention that Mr. Nicolai had given to his subject was shown in the excellence of the detail he submitted, and the Society may consider the new session very successfully started by his paper. A superficial discussion followed, much of which was in lighter vein.

One comment must be made and this in defence of the Committee's efforts. Quite so large an attendance was not anticipated and the labour of serving tea to all at once was too considerable for the serving staff, especially with each of the audi-

ance sitting between two others whose idea of tea was a little ahead of his own. However, new men will find this matter fully adjusted by the next meeting when Mr. Warner reads his paper, "Impressions."

The President's Address.

Gentlemen,—

At the beginning of each Session of the Guy's Hospital Dental Society it is customary for your President to address a few remarks before the general business of the Meeting is taken.

In the first place I wish to acknowledge my keen appreciation of the honour you have conferred upon me in asking me to take the chair at these meetings for the third time since I became a member of the Guy's Staff.

This Society was established in 1894 when I was a first year's student of this Hospital, and having watched its progress during the course of twenty-eight years I am convinced that it fills a very important place in the life and spirit of the Dental School.

A Student's Society offers a considerable service to the work of education. It is one of those agencies which help to popularise the common store of knowledge, and it affords great possibilities for self-education. Furthermore, Students' Societies tend to counteract the evil of unfruitful cramming and to lift their members to a wider culture and to a power of more thoughtful criticism. At the same time they afford an excellent incentive to all good workers.

I suppose that most of us at the beginning of a career start with the desire to attain some measure of success in the calling which we have chosen for our life's work, and yet, a very large number of men fail in their efforts to attain success. Why is this?

In one of the daily papers some time ago there appeared a series of cartoons illustrating the general incompetence of people to do their own particular job.

There was the bricklayer who knows all about Tariff Reform but cannot lay bricks.

There was the cook who knows all about the Insurance Act but cannot cook a joint.

There was the tailor who could tell you all about farming but he cannot make a suit of clothes to fit.

And, there was the accountant who says he is an expert on pictures but he cannot add up figures correctly.

Now what does this all mean? Well, I think it means that there are a great many people who will not concentrate on their own work. They always want to be doing something else. Such people can never hope to make a success of their calling.

An Oxford worthy once said that choosing a business or a profession is like choosing a wife, in that it does not matter so much what a man chooses so long as he is faithful to what he has chosen. I do not mean to infer that the choice is unimportant, but having made the choice stick to it if it is possible for you to do so, for constancy is essential to success.

In a book which Lord Riddell has recently published entitled "Some things that matter," he has endeavoured to show us that Concentration is the secret of success in all the management of human affairs.

He begins his book with the pregnant sentences "Observation, Concentration, and Memory are all closely allied: Interest is the basis of all three." If you want to make your work easy take an interest in it and when interest is aroused concentration will follow, also if once a student becomes interested in a subject its study is no longer a toil.

Sidney Smith has advised us to have the courage to be ignorant of a great many things in order to avoid the calamity of being ignorant of everything.

People have very different ideas as to what success really is?

Is it the ability to accumulate wealth?

Is it the attainment of a prominent position?

Is it the gaining of power and influence?

Is it the ability to perform perfect operations?

To my mind it is none of these.

Life at the end will seem a poor affair if the fruits of its exertions are to be no more than material and monetary acquisitions. What matters when our labour is over, is not the apparent failure nor the apparent success of our efforts, but what we are in ourselves and what the character is that remains when the "hurly burly" is done. Success then, should be estimated by what a man is, by the amount of good he has done, by the respect and confidence of the profession, and by an honestly won reputation amongst the public.

And now, for a moment, let me turn your attention to one other matter.

We often boast about the progress that our profession has made during the last half century. Great progress has been made I fully admit, but, when we consider carefully, how little do we really yet know of the processes of the disease?

Sir Watson Cheyne put this matter very concisely some time ago, "Medicine," he said, "is not yet an exact science and a good deal of what students are being taught is not true. When we come to deal with life we know so little about the actions of the living body that we cannot be dogmatic. We can lay down hypotheses which will hold for a day and then pass away, and just as teaching forty years ago seems to us to be very curious, and not very

sound, so it will be exactly the same forty years hence."

How quickly time makes every one of us out of date.

What we need, therefore, at the present day is a large band of researchers. It has been said in some quarters that the Dental Students of Guy's Hospital have failed to devote themselves to research work. I consider this to be an unfair criticism, yet at the same time, I am sure it would be possible for us to do much more in this direction than has been done in the past.

There are many fields essential to the progress of Dentistry which are yet unexplored, and I appeal especially to the freshmen to acquire the habit of enquiry from the commencement of their career. I would not underestimate the difficulty of research, nor the energy and amount of concentration that will be needed, but I would emphasise, what has been said elsewhere, that next to doing an unselfish kindness the act of discovering something yields the greatest, keenest, and most lasting joy of which the human being is capable.

In a society such as this you have one of the best opportunities of developing that desire for research.

In connection with the celebrations of the tercenterary of Harvard University there was a long procession representing all the grades and stages of University life. The great deeds of those who had passed through the University were recorded on the banners carried in that procession. One after another the representatives of different periods passed by. Then last of all came the first year's students and they had emblazoned on their banner the words "Harvard has been waiting 300 years for us."

We are told it was towards the end of the year 1722 that the original building of Guy's Hospital was begun, and, although the roof was not completed until December, 1724, it may be said that these Hospital Buildings came into existence just 200 years ago.

Perhaps some of you who have recently become students would like to copy the men of Harvard and say "Guy's Hospital has been waiting 200 years for us." If so, my reply would be "See to it that you make good and enhance the solid reputation which Guy's has made in the past."

Change of Address.

Dr. J. A. Martin, Mission Hospital, North West Frontier Province, India.

Philip L. Richardson, 345, South Norwood Hill, S.E. 25.

Surg.-Lieut. N. A. Barlow, H.M.S. *Repulse*, c/o G.P.O., London.

The Relationship of Oral Sepsis to General Disease.

Paper read before the Dental Society on Thursday, October 19th, 1922.

Mr. President and Gentlemen,—

The subject of Oral Sepsis and its relationship to General Diseases is a vast one, and if I were to present it to you in all its detail to-night I should need your attention for weeks instead of hours, and would need infinitely more knowledge and ability myself in order to present it to you in its entirety.

Not wishing to endanger the progress of our Society by such strenuous demands, I have merely brought forward some of the salient features of this discussion upon oral sepsis and general disease for your consideration.

Introductory.

The most interesting and satisfactory method of investigating the relationship of oral sepsis to general disease is to consider first the normal condition and relationship of the cells of the various tissues of the body and their disordered condition. Then by comprehending the physiology and pathology of the cells of the body one obtains a much clearer insight into the special conditions of disorders of organs and systems, as a result of oral sepsis and oral infection, and one has further the satisfaction of knowing that such knowledge is basic.

This fundamental knowledge cannot be entered into in a short treatise such as this, but we can at all events summarise the facts according to Virchow.

"There may be interference with any of the three great varieties of cell (and consequently of tissue) activity; namely, nutrition, reproduction, and special function. Further, we must bear in mind the various channels or modes of access by which injurious agents may attack the tissues and their component cells. Thus they may act directly upon them, for example upon a free surface; they may be carried to them by the blood stream or lymphatics; or they may act indirectly through the mechanism of the nervous system; or by impairing some other bodily function which is necessary for the health of some, or perhaps even all of the tissues, for example, the secretion of the thyroid gland."

Now in conjunction with this idea of the normal activity of a cell, consider, too, the difference that exists between the highly specialised cells of the human body, and the simplest forms of life, as seen in the amœba. The amœba being a unicellular animal obviously has no differentiation of cells, and the one cell which constitutes the amœba has to

carry on all the essentials of life. There is in consequence a remarkable power of recovery from injury latent in the amœba.

Not so in man. Specialisation of cell function is necessary on account of the size of the body, but with specialisation of function goes the unavoidable weakness of the cell, so that the cell performs its special function most admirably, but at the same time lays itself open to attack by its inability to feed itself, to protect itself, to get rid of waste products and even to carry on reproduction.

Thus the more highly specialised a cell is (except indeed if its specialisation be for defensive purposes) the more vulnerable it is to the attacks of organisms and toxins.

Fortunately nature has made provision for the weakness of these specialised cells in the higher animals by the production, and circulation in the blood of the animal, of antibodies, and these antibodies have the property of attacking invading bacteria.

These antibodies comprise the agglutinus bacteriolysins, and antitoxins. Details cannot be entered into here as the subject is exceedingly complex. The general principle though of the mode of action of antibodies is that normally they are absent, or only present in small amount in the blood, but when infection takes place they are produced in large numbers in order to cope with the infection.

So, when we observe a condition of oral sepsis we know just how the sepsis can affect the cells of the body, and further which cells are most vulnerable to its attack.

Oral Sepsis.

I prefer to divide the conditions of oral sepsis into three classes, for the purposes of this treatise.

The first class is that in which the sepsis is quite apparent and is obviously causing trouble. The condition is easy to diagnose, and is in no danger of being overlooked. For example, a case of chronic general periodontitis.

The second class is of infections more obscurely hidden, such as an apical infection, which in many cases is only indicated by skiagrams, and may even be missed by the X-rays. Such a condition is a grave menace to the health of the patient, by reason of its obscurity.

The third class is one in which the sepsis, although present in the oral cavity, calls for medical treatment, and only concerns us as Dental Surgeons, in the diagnosis of the condition and the transference of the patient into medical hands. Diphtheria is an example of this class.

General Diseases.

These can be more easily discussed under the heading of "Spread of infection," because the diseases that arise can all be accounted for by the knowledge of the method of spread of infection, and cellular pathology.

Method of Spread.

There are four methods of spread of infection from the mouth.

1. By direct continuity of tissue.
2. By spread along mucous surfaces (alimentary tract trachea, Eustachian tube, nasopharynx, etc.)
3. By lymphatics.
4. By the blood stream.

1. Following direct spread, one may have—

Types of spreading cellulitis, necrosis of the jaw, and suppuration of the antrum.

2. Spread along mucous surfaces—

By this route the whole of the alimentary canal and the glands and organs that open into it are exposed to infection and there are only three defensive measures on the part of the body to be overcome by the bacteria for these to gain access to the delicate mucous membrane of the stomach and intestines. These are the tonsils, the gastric juice, and the bacillus coli of the large intestine.

Through constant infection in chronic cases these natural barriers are broken down; the tonsils are enlarged, and do not function; the gastric secretion loses its acidity and antiseptic properties, the delicate cells of the gastric and duodenal mucous membrane are easily damaged, and so the alimentary troubles are started.

The diseases that follow are merely an application of the suffix "itis" to the anatomy of the alimentary canal, to indicate inflammatory conditions.

Those deserving special mention on account their frequent occurrence, are gastritis, gastric ulcer, and constipation.

By further spread the glands opening into the alimentary canal may become involved giving pancreatitis—jaundice.

Spread along mucous surfaces is responsible for inflammation of the air sinuses of the skull, otitis media (via the Eustachian tube) laryngitis, bronchitis.

3. Spread by lymphatics—

The cervical lymphatic glands may, and in the majority of cases do, become infected, from the septic areas which drain into them. These glands become enlarged, fibrosis occurs, and being thus permanently weakened, they are very apt to become tubercular.

4. Spread by the blood stream carries infection to the most distant and seemingly inaccessible parts of the body. Rheumatoid arthritis is one of the commonest results of spread by the blood stream of oral sepsis.

Besides this, these conditions occur—anæmia, chronic rheumatism, septic endocarditis, purpura, chronic nephritis, neurasthenia, conjunctivitis, affections of the intra- and extra-ocular muscles of the eye, neuralgia, skin diseases such as pruritis, erythema multiforme, chronic urticaria, and furunculosis.

Degree of Infection.

From a septic focus, as in oral sepsis, destruction of the tissues may be due to the circulation of poisonous metabolic products of the bacteria, which remain localised at the site of infection; a condition of toxiæmia; or the bacteria may be carried to other parts of the body and liberate their toxins there—a condition of septicæmia.

In diphtheria the bacilli remain localised in the mouth, and only the toxins circulate in the body producing the most harmful effects. In septic endocarditis, the bacteria themselves, are carried to the seat of secondary infection.

The Relationship.

Now that oral sepsis, the general diseases arising from it, the method of spread have all been discussed, let us enter into the relationship between the two conditions.

There are two arguments, having reference to this subject, that have given rise to much controversy and have at various times, been discussed in the "Lancet."

The *first* is whether general diseases are caused by *direct* infection of the tissues, by the same bacteria as are present in the mouth, or whether the oral bacteria and toxins only weaken the resistance of the tissues and subsequent invasion by extraneous organisms takes place.

The weakening of the tissues and subsequent invasion is a very probable explanation of many infections—for example, the infected cervical glands of the neck which become tubercular in the course of time.

Yet cases are recorded in which identical streptococci have been isolated from septic foci in the mouth, and in joint cavities affected with arthritis, thus indicating a direct infection of tissues.

The most reasonable explanation is that both types of infection may occur, and it only rests with the virulence of the organism from the septic mouth, and the resistive powers of the patient as to which condition supervenes.

In this connection the evidence of Rosenowe's experiments is of interest. He has shown that streptococcal cultures when obtained from various lesions in man, upon injection into healthy rabbits give rise to lesions, *in the same tissue*, in the injected rabbits—thus a streptococcus from an infected appendix of man gavie rise to appendicitis when injected into the rabbit. This demonstrates the selective capacity among pathogenic organisms of the same group, for certain tissues of the body—a point in favour of secondary infection after lowering of resistance.

The second argument is more difficult to dismiss. The relationship between oral sepsis and intestinal infection is apparent, but is the original site of infection the mouth or the colon, and which is the more important focus?

Warren Crowe gives evidence of vaccine treatment of 160 cases of fibrositis, arthritis and neuritis. In these he states that only 10 were wholly due to the teeth, in 46 the teeth were probably contributory—or in other words, only in 33 per cent. of cases did the teeth have anything at all to do with the matter.

Fæcal streptococci, he found, gave a much greater reaction on inoculation than dental streptococci, and the vaccines were correspondingly more effective from fæcal material than from dental tissues. So it would seem that the colon contained the more important focus.

Even if we can prove the intestinal focus the more important it does not decide the original site of infection, and certainly does not indicate that dental foci, because they are secondary, may be neglected.

Conclusion.

One must not lose sight of the fact that oral sepsis is but one of many factors that may be responsible for the infection which produces general disease. The mouth may be the only source of infection; it may be the predominating source of infection; it may be a minor source of infection; and it may not be responsible for any infection at all. Therefore one must remember the possibility of other septic foci in searching for the seat of trouble in general diseases.

For example arthritis may be, and very often is due to vaginal infection (gonococcal for example) and one must recognise the vagina as a very likely source of infection. Or again the colon may become a focus which is secondary in its appearance as a focus, but primary in the virulence of its organisms. Enlargement of the submaxillary lymphatic glands is a condition almost unconsciously associated with infections from the mouth and tonsils, yet infection of these glands from the scalp invaded by the pediculi capitis occurs in some patients when the mouth is perfectly healthy.

Further, it is to be borne in mind that a long-standing condition of oral sepsis which has received treatment and has cleared up, has been the original cause of the trouble but its removal does not imply the correction of damage which it has caused. The removal of sepsis from the mouth is only of value in that the body is left free to repair broken down and infected tissues instead of dividing its activities between the combating of oral sepsis on the one hand and the repair of tissues on the other.

It rests with the amount of damage done, whether complete repair is possible or not.

A general anæmia, weakness, debility can be overcome by the removal of the source of irritation and infection without leaving any trace of disorder. A gastritis followed by a gastric ulcer is a condition not easily restored to the normal, as one may realise by the fact that the ulcerated gastric mucous membrane is replaced by scar tissue, and that a permanent injury and weakness results, although the original trouble of oral sepsis may have been successfully removed.

We must therefore be careful in diagnosing the existing conditions, to do so very accurately, at the commencement of treatment, so that we may form a reasonably accurate prognosis of the case; for it is the prognosis of a case that concerns the patient more than anything else, when he seeks medical advice, and if we can satisfy him on that point, we shall go far toward winning his confidence, and further our trouble will be amply repaid, by having a definite knowledge upon which to base our treatment.

REFERENCES.

1. Beattie and Dickson. *Pathology*, pp. 28—29.
2. *Dental Record*, May, 1922.
3. Hewlett's *Bacteriology*, p. 176.
4. *Lancet*, April 22nd, 1922. Warren Crowe.

Patients I have Treated.

ANTONIO.

I sometimes feel inclined to write my reminiscences but the wife seems to have a rooted objection to anything that appertains to my old life. I am up for a churchwarden's job next year and she is in desperate fear that some old skeleton should force its way out of the cupboard and spoil my chance. Jim Wilson nearly did it the other night. He was assayer on the old Sam Felix property and meeting him in town I brought him back to dinner, forgetting that the Vicar was coming. I never noticed he had stood too long at the cocktail bar, but I squared Ethel by telling her that he had the fever rising on him, as well as having an impediment in his speech. He told some nice tales did Jim; and what seemed decidedly funny at the club in Manaos or in the Ice House at Port of Spain, sounded positively bloodthirsty in Peckham. Still, he need not have mentioned about that slimy Syrian, Pouofolos, and the row we had at San Felipe. Oh! I shot him right enough, but you see I had never told Ethel about that and I am supposed to have confessed everything. But, joking apart, I was very uneasy during that dinner. The Vicar has a dry nervous cough that eloquently expresses disapproval, while the wife's clear blue eyes are positively disconcerting when they get properly fixed on a man.

Oh! I am happy enough, but life at times seems a bit humdrum, especially when the night bell suddenly rings and instead of grabbing the butt end of your gun, you find you are holding the baby's rattle. It is difficult at times to prevent the mind wandering, especially when the weather is hot.

. . . . . .

It was the hour of the siesta. The sun stood flaming in the zenith and in the intense heat, even nature seemed torpid and desirous of sleep. The birds ceased twittering in the trees and the gorgeous parrots stopped squawking and squabbling in the bush. In front of the Prefecture, the village policeman had let his Mauser slip from his fingers, as he dozed unblushingly against the doorpost. Above his head a gaudy flag drooped dismally from the mast, while, attracted by its brilliant colours, a cloud of richly painted butterflies flaunted their beauties around it.

To get out of the heat I tied my mule to the hitching rail and went into Natty's saloon. I shook the dice with the clerk for a whisky and was just about to drink when a row started up. What Antonio had done to irritate the tonka bean gatherer I do not know, but the latter spat an insult at Tony—an insult that no South American forgives. I saw the knife blade flash in Antonio's hand before his opponent had got his Smith and Wesson clear of the holster. A choking sound came from his lips as he fell prone over a coffee bag. Another flash and the knife was buried to the hilt just under the shoulder blade. There was little for a doctor to do and the man died before I could collect my fee; nor could I get a grip on his sack of tonka beans for Natty had seized that for the drinks before Antonio had wiped his knife. He was a smart man was Tony, with a lance blade; to see him whip it out was like watching a conjuring trick. Moreover, he was the second best revolver shot between the Orinoco and the Amazon, modesty forbidding me to mention the best. I nearly got a round myself once and if you promise not to mention it to the wife I will tell you what happened.

Pedro the Corsican gave a dance one night to celebrate taking five thousand pesos' worth of gold out of his new barranco. I shall not forget that night in a hurry for Pedro's crazy lamp leaked so badly that I nearly got drenched with Rockfeller's worst brand of kerosene, and when I got back to the shack, Mercedes refused to let me in, thinking I had been

skunked. But about this row with Antonio. What did we quarrel about? A girl of course; for what else is there to quarrel about when the heart is young and a tropical sun turns the blood to liquid fire? Briefly, Antonio accused me of kissing his girl, Lolita. What an infamous suggestion! I thought of bringing an action for defamation of character against him but—well, well, the scratches on my face were still bleeding. She was a little spitfire was Lolita. However, we did not quarrel long about her for the next day she went off with Pedro. It was a sad blow to Tony and myself, for in those days we were good looking fellows and Pedro was bald, fat and middle-aged. Moreover, he had no front teeth; a warder at the French Penal Settlement at Cayenne had knocked those down his throat with a rifle butt some years before. But as Pedro used to say, as you get older you have to rely more on your pocket book than your good looks, if you want success in love affairs. He died soon after and I am glad of it, for I never liked the man.

The day after the dance, I was called in professionally by Antonio and as the present state of his face leaves much to be desired and in consequence, my skill as a surgeon has been called in question, I had better state exactly what happened. The morning was exceptionally hot and Antonio turned into Pancho's saloon for a refresher. He was foolish enough to remark to Pancho's girl that the weather must be very trying to stout people. The poor fool might have known what most of us learned in our childhood, that this is a delicate topic to broach to a lady who is losing the contours of youth. At all events Innocencia, for that was her name, struck him on the mouth with the rum bottle. He came running into my office with the blood streaming down his face. I was unable, of course, to restore his teeth, but I made a splendid job of his lips, putting in no less than 20 stitches. I then cautioned him to quit drinking and stay in his hammock for the rest of the day. In the afternoon, however, feeling a bit lonesome he went round to the cockfight. Here someone slipped him a bad dollar and Tony was foolish enough to fix the blame on a Canadian prospector. Poor Antonio was badly handicapped as he had been forced to leave his weapons at the door of the cockpit. Still, judging by the condition of both of them when they came to my office, it must have been a grand fight and I shall always regret having missed it. The Canadian paid me with a horse, which I found later, to my disgust, had been lent him for the day by a rubber bleeder. As for Antonio I never expected to get much out of him, but fortunately a revolution came along and he was made District Judge. I never lost a case in the courts after that.

E. H. G.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Save the Children Fund.

DEAR MR. EDITOR,—I have received the enclosed letter and shall be glad if you will print it with this. I understand that with the new harvest in Russia there is little further need for relief work among adults, but very great need for money to continue feeding the children, especially the orphans, who have been saved. I believe that the money which has been given from British sources has been well and economically spent and has resulted in the saving of thousands of lives.

I received fifty pounds in answer to my letter in the Xmas Number of the GAZETTE, and shall be pleased to acknowledge subscriptions from any others who feel that they would like the work of this particular kitchen to be completed.—I am, Sir, yours faithfully,

J. M. H. CAMPBELL.

Guy's Hospital,
London, S.E. 1.
November 15th, 1922.

Dear Sir,—

We have twice received sums of £25 from you on behalf of the Students and Staff of Guy's Hospital, thereby enabling us to open a Russian kitchen in their name in the famine district of Saratov.

The total sum needed for one such Kitchen is £100, and I am therefore writing to ask you whether it will be possible to complete this amount and thus realise the original undertaking. It is a difficult time to ask you for further help I know, but you will understand our Russian work is by no means over.

Yours faithfully,

A. LEGGETT,
Chief Organiser.
SAVE THE CHILDREN FUND.

A Wireless Apparatus in the Medical School.

DEAR MR. EDITOR,—It is proposed to purchase a Wireless Receiving Apparatus for the School, by private subscription. A sum of £50 is required, and it is hoped that those who are interested in the

subject will be willing to subscribe. Dr. Fison has set the ball rolling with a donation of £10, and I have already received nearly £20 towards the total sum.

Subscriptions should be sent to me at the Medical School Office.—I am, yours faithfully,

T. B. JOHNSTON,
Dean.

Medical School,
Guy's Hospital,
London Bridge, S.E.1.
November 22nd, 1922.

Infant Welfare Work in New Zealand.

DEAR SIR,—I do not know if you are still the same Editor who occupied "The Chair" when I last wrote for the GAZETTE last October. Much water has passed under the bridge since then. I have met several old Guy's men out here, and been closely connected with Dr. Martin B. M. Tweed, who is now married and in practice at Carterton, Wairarapa —there's a jaw-breaker!—not far from Wellington. He is most keen on "Plunket Work" out here; has formed a branch of the Society there, and in all New Zealand, for size of the place, has the largest number of members and in such a short time. He is particularly keen, so of course is any one—father, mother, nurse and doctor—who has seen or tried Dr. Truby King's methods. I have sent you quite a lot of good cuttings of the new Government Report. There are many Guy's men out here whom we have met since the Government campaign started, in the South of the South Island in March last, who are interested.

People at home have no idea of the magnitude of the work of the Plunket Society in New Zealand. It is no dilletanté collection of women, but committees of women with strong advisory boards of business and professional men. The branches have organised all this Campaign for the Government. We have no live Society at home spread throughout the length and breadth of the land working so harmoniously, uniformly, and authoritatively. Now the System has, as you know, spread to London, where I trained under Dr. King himself at Earl's Court. A similar baby (Karitane) Hospital (Karitane is the Maori name of the house which became the first hospital, so that in New Zealand and for T. K. trained nurses anywhere, a "Karitane Hospital" is one run on Dr. T. K. lines) is now in Sydney in charge of an Australian who trained at London Karitane after war service. This is now a Sydney training school on Plunket lines. Melbourne is running T. K. Clinics and collecting for a hospital... Tasmania, Supt. Nurse P. H. Dept., T. King, trained in London with me. Launceston and Hobart Clinics are all staffed with nurses who were sent over here to train. Last week the Prime Minister here had a cable from the Queensland Government. Nurse to be sent to train here prior to Government opening new model infant clinic—wonderful spread of the work. Dr. King lectured all over Australia in 1919. He could not get to South Africa, they want me now for six months.

I am writing under great pressure to catch the mail. I know you used always to be glad of copy in the old days, and judging from a letter in the GAZETTE in October, some of the home Guy's men do not realise how this work has spread.—Yours truly.

J. B. N. PATERSON.

Department of Health,
Wellington, New Zealand.
October 16th, 1922.

Notices.

Old Guy's man has Consulting Room to let. Cavendish Square end of Harley Street. Suitable for Surgeon or Physician. Can be inspected.

Further particulars on application to:—
The Secretary,
15, Harley Street, W.1.

Books.

Messrs. J. & A. Churchill expect to publish shortly a new work entitled "The Theory of Emulsions and Emulsification," by Dr. W. Clayton. The volume has a Foreword by Prof. F. G. Donnan, F.R.S. The second edition of Dr. J. D. Gimlette's "Malay Poisons and Charm Cures" is nearly ready. For this edition Sir W. Willcox, K.C.I.E., C.B., etc., has written a Foreword.

Other volumes which will be published in a few weeks' time are "Sterility in Women, Its Causes and Treatment," by Dr. R. A. Gibbons; "Applied Pharmacology," by A. J. Clark, Professor of Pharmacology, University College, and the eighth edition of "Tomes' Dental Anatomy," edited by Dr. Marett Tims and Mr. C. Bowler Henry.

Royal College of Surgeons of England.

BRADSHAW LECTURE.

Notice is hereby given that the Bradshaw Lecture will be delivered in the Theatre of the College in Lincoln's Inn Fields, by Sir William Thorburn, K.B.E., C.B., C.M.G., on Friday, the 8th of December, 1922, at 5 o'clock p.m., precisely.

The subject of the Lecture will be "The Surgery of the Spinal Cord."

Fellows and Members of the College are invited to attend. Students and others, who are not Fellows or Members of the College, will be admitted on presenting their private visiting cards.

S. FORREST COWELL,
Secretary.

THOMAS VICARY LECTURE.

Notice is hereby given that the Thomas Vicary Lecture will be delivered in the Theatre of the College in Lincoln's Inn Fields, by Mr. Walter G. Spencer, O.B.E., M.S., F.R.C.S., on Thursday, the 14th of December, 1922, at 5 o'clock p.m., precisely.

The subject of the Lecture will be "Vesalius and his Delineation of the Framework of the Human Body."

Fellows and Members of the College are invited to attend. Students and others, who are not Fellows or Members of the College, will be admitted on presenting their private visiting cards.

S. FORREST COWELL,
Secretary.

Pass List.

Royal College of Physicians.

M.R.C.P.

OCTOBER, 1922.

A. H. Douthwaite.

University of London.

3rd (M.B., B.S.) Examination.

OCTOBER, 1922.

Honours.

G. W. Heckels (Distinguished in Surgery).

Pass.

P. L. Richardson. C. H. St. John.

Group I.

S. Crown. E. A. Leviseur.
G. W. Elkington.

Group II.

B. L. Laver. A. H. Shelswell.
F. R. Leblanc.

L.D.S.

FINAL EXAMINATION. NOVEMBER, 1922.

*F. A. Simpson.	A. S. T. Garland.
*I. R. Mutch.	L. J. Godden.
F. A. Nicolai.	G. W. Griffith.
A. F. Porter.	G. T. Hankey.
S. E. Sennitt.	J. B. Hine.
H. Wayman.	S. T. Hine.
*V. R. Roberts.	K. Hooper.
*E. V. Walmsley.	J. A. Hudson.
*J. V. Bingay.	F. G. Hutchinson.
*R. Edwards.	R. H. Muller.
*C. D. Farris.	M. Patlansky.
*H. D. Hall.	B. Rubinstein.
*E. V. Hayes.	E. Samuels.
*F. A. Kerrison.	E. A. Sheppard.
R. C. Andrews.	H. Slater.
W. O. Bailey.	C. H. Stevens.
D. J. Baker.	W. H. Taylor.
G. Beamish.	A. K. Van Niekerk.
G. H. M. Woodbridge.	H. J. Walters.
C. C. Brattle.	W. J. Williams.
A. J. Britz.	C. B. Wilson.
T. C. Butler.	*T. S. Lloyd.
A. Clarki.	*E. A. Lloyd.
J. S. Dick.	*C. T. Pomeroy.
J. E. V. Duckworth.	*F. R. Payne.
L. Evans.	*R. C. May.
F. J. Fourie.	*J. E. B. Smith.
F. C. Gardenner.	L. B. Helder.

Papers by Guy's Men.

P. P. Laidlaw and W. W. Payne. A Method for the Estimation of Small Quantities of Calcium.—*Bio-Chemical Journal*, xvi. 1922, p. 494.

C. Worster Drought, M.A., M.D., M.R.C.P., and Other. Observations on the Colloidal Gold Reaction in Neurosyphilis and other diseases of the Central Nervous System.—*Lancet*, ii., 1922, p. 1063.

Reviews.

Aids to Dental Anatomy and Physiology. By Underwood. (Mesrss. Ballière, Tindall and Cox.) Price 3s. 6d.

A fourth edition of this useful work has now been issued and the popularity of a book which can reach its fourth edition does not need a reviewer's further comments. Dental students will find this compact revised edition of considerable value for reference and quick revision.

Physiology for Dental Students. By A. Curzon Miller. (Messrs. Edward Arnold & Co.) Price 10s. 6d.

This book is both concise and of considerable practical value to dental students for it has maintained the Dental Syllabus in Physiology without unnecessary departure. More importantly it is a book possessing many excellent photomicrographs in the section devoted to a brief résumé of Histology as applied to Dental Studies, and the remaining illustrations are also equally commendable although a diagram of uriniferous tubules gives fifteen reference numbers which are ignored in the text. A book from which one may learn without confusion of detail and should find a place in every dental student's collection.

Dental Surgery, Questions and Answers. By Barritt. (Messrs. Henry Kimpton.)

This book is of the question and answer type and for those who find catechism an aid it will have its purpose. It should not be regarded as a book for which one may study, nor has it reference value, but it holds the possibility of benefiting students working together on an agreed system of viva voce, inasmuch as the questions are both concise and probable, and the answers, in their condensed form, a useful check.

Materia Medica for Dental Students and Practitioners. By Coleman. (Messrs. Henry Frowde, Hodder and Stoughton.) Price 10s. 6d.

This is a very complete and carefully arranged volume. The indexing is good, the text clear, and the subject comprehensively detailed and from the student's point of view contains all that he is likely to require for examination purposes. It possesses the further merit of being a book that used while one is a student is also equally useful when one is in practice. Essentially a book for the student and the practitioner.

Rugby.

GUY'S v. COVENTRY.

At home on Saturday, November 11th, the Hospital added one more victory to their growing list of successes, by defeating Coventry by 2 penalty goals and 2 tries to 1 dropped goal, (12 points to 4).

Instead of Daneel, Hirschberg was tried at full back, and it may be said at once that that position is not Hirschberg's. The day was against him, as foothold was precarious and the ball most difficult to hold. This difficulty did not worry the three-quarters, who passed with their usual accuracy, but naturally not at their usual speed. This allowed the Coventry defence to concentrate at the danger point, hence the scoring was low. Sprong did not turn out and Finnemore, who took his place, was quite good. He gave his passes well and was on the move at once, Bekker had some difficulty in understanding Elton, the Coventry scrum half, who stood offside more or less constantly. The referee gave numerous penalties, but this failed to cure Elton, who seemed desirous of studying Bekker's methods from all points of view. Doherty played well. One piece of play between him and Bekker deserved to score, but eventually the deserved score came from a good cross kick by Steyn. Several forwards, Taylor, Scolefield, Neser and Holloway, were up, and the former gained the try, but though conversion should have been easy no goal resulted. A fine drop kick by Albertijn brought us another three points, a penalty being awarded some distance from the goal-line.

In the second half our backs did not get quite so many opportunities. Coventry were more aggressive, chiefly by forward rushes. The visiting threequarters did not bring off much in the way of combined attack. On the other hand our men brought off some startling rounds of passing, which at length met with success, Steyn going over, after all the backs had handled. The passing was chiefly to the

right, so Mostert had few chances. A cut head, which he sustained, did not do him any good. Albertijn was next in the picture with another dropped goal from another penalty and at this our scoring stopped. Van Schalkwijk made some clever runs, but one thought he might with advantage have got rid of the ball sooner on one or two occasions. With the end approaching Coventry gained a foothold about our 25 yard line and Pemberton dropped a neat goal, the game ending soon after with the score as above.

Guy's Team.—A. Hirschberg, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, C. R. Mostert, F. Bekker, H. Finnemore, W. D. Doherty, W. H. Taylor, E. E. Neser, E. H. Fouraker, B. G. Scholefield, F. G. Hutchinson, N. M. Holloway, P. G. Harvey.

GUY'S v. CAMBRIDGE UNIVERSITY.

The University beat us on Wednesday, November 15th, at Cambridge, by the margin of 13 points to 3 (2 goals and 1 try to 1 try), and all unbiassed folk will say that they fully deserved to win. We were almost there many times, but not quite, and this is the reason of our defeat, just that lacking of the final burst that breasts the tape, before the other fellow. Sprong was not there to assist, neither was Mostert, but their substitutes, Finnemore and Hirschberg, did very well indeed.

The Cambridge pack was lively in the extreme; Wakefield, Morel, Tucker, especially, seemed away first from every scrummage, and in among our attack before they could get away with the ball. We were the first to score, Albertijn going over the line after beating the Cambridge defence very cleverly. Both Francis and Gardiner bought that oft-sold dummy, and as neither had so far this year met Albertijn there is some excuse for their easy purchase. One rather thought that Tucker got a try against us just after, but it was disallowed and we once again got to midfield, where the threequarters were compelled to kick rather than run. Cambridge soon scored through Mackenzie, who ran excellently and put Tucker, of Caius, in. It was a great afternoon for this Cambridge forward, who got another try after the half-time interval. But before that period Steyn raced down the field at a tremendous pace to be caught just by the corner flag by MacKenzie, of Peterhouse, a fast threequarter belonging to the Navy, who came right across to bring off a great tackle. Young got another try for the Light Blues before the end.

There the story ends. About 20 minutes before the close W. D. Doherty was injured and had to leave the field. E. H. Fouraker also sustained severe damage, and one fears that both these excellent forwards will have to join R. F. H. Duncan in retirement for a few weeks. It is bad luck for the Hospital that a trio of such calibre should not be for the present available.

Guy's Team.—S. H. Daneel, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, A. Hirschberg, F. Bekker, J. W. Finnemore, W. D. Doherty, W. H. Taylor, E. H. Fouraker, E. E. Neser, B. G. Scholefield, M. N. Holloway, F. G. Hutchinson, P. G. Harvey.

GUY'S v. LONDON SCOTTISH.

On Saturday, November 18th, the Hospital was again defeated, this time by the London Scottish. The Guy's team was, it is true, much depleted by illness. The Scottish forwards so controlled the game that Guy's were quite overwhelmed. In the first place Albertijn was forced to dodge behind his line and punt out. Duncan, the Scots back, caught the ball and dropped splendidly for success. It is not often Albertijn fails to find touch, but this time he did, and we had to pay for it. Steyn scored splendidly for us soon after, coming across from right to left and taking the ball in his stride. On another occasion Van Schalkwijk flung his pass so wide that Steyn coundn't touch it. Hutchinson started this movement. A great game Hutchinson played. So did Holloway. Harvey played himself out completely. Du Toit helped all he knew, and the other forwards pushed hard enough in any case, if they were not in evidence in the loose, they heeled well and no winging was done. Just before half-time Steyn's leg gave out; in full cry for the line he had to stop, put the ball down, and sink to the ground. That ended our chances, but no team could have continued more pluckily—Neser's valuable help was transferred to Steyn's vacant post for the second half, where he did not get one single pass. He should have had, but his centre would not part. The halves failed to field cleanly, but Finnemore showed his centres the ball many times. The centres should tackle more thoroughly. In defence they were very poor. Nurick was given much to do, and one must say his few mistakes should be forgotten when one remembers his perpetual pluck and resource under trying circumstances. Neser helped valiantly in defence. He wasn't allowed to attack. Orsmond was good, but he should use his pace for all it's worth.

Another try came to the Scots, quite well worked for. The first one they got should never have been, bad tackling gave it them. On time Grant dropped a good and clever goal. A free to us was miskicked, the position was our goal-line, a maul ensued, Grant secured and did the rest.

Those good fellows who filled the breach at Richmond are to be congratulated. They undertook a great task, they fell short of success, but they showed the right spirit in turning out, some of them at short notice. The Scotchmen were enormously elated at the result, good luck to them, it wasn't their fault they did not meet our full strength. The full score was London Scots.—2 dropped goals, 1 goal and 1 try (16 points); Guy's, 1 try (3 point).

In acclaiming the downfall of Guy's, it would have been welcome to have heard just a murmur of regret at the absence of W. D. Doherty, R. F. H. Duncan, E. F. Fouraker, W. H. Taylor, B. G. Scholefield, F. Bekker, E. L. Sprong, G. R. Mostert, S. H. Daneel. I wish we had a return match this season. On the other hand as the man says in "The Cat and the Cradle," perhaps it is well we haven't.

Guy's Team.—L. Nurick, C. L. Steyn, J. G. Van Schalkwijk, P. K. Albertijn, W. Orsmond, J. W. Finnemore, W. H. Meisner, F. G. Hutchinson, E. E. Neser, W. M. Holloway, P. G. Harvey, P. J. Du Toit, N. L. Eckhoff, W. Roper, V. W. Percival.

Association.

GUY'S v. KING'S COLLEGE.

(University of London Cup—First Round).

On Wednesday, November 22nd, we met King's (the holders) on their ground at Mitcham.

The game started sensationally, Couch scoring our first goal, after a few minutes play, as a result of splendid combination in the forward line.

Both teams played excellent football, Guy's however, showing greater superiority in front of goal. A very fast game was experienced, the ball passing from one goal to the other continually. Much to the delight of the Guy's supporters, Couch again scored before the whistle blew for half-time.

On resuming King's made radical changes in the team, the most noticeable being Matthews from right back to centre forward. King's pressed hard, keeping Wooldridge busy, and during one of their raids, a foul was given against Guy's in the penalty area. Matthews took the kick and made no mistake, thus King's obtained their only goal of the match.

Couch again scored, and before the final whistle blew Gonsalves, working over to the right side of the field, sent in a high shot which completely beat the opposing goalkeeper.

Wakeford at right back undoubtedly played a magnificent game, his kicking and tackling was very fine.

Hockey.

GUY'S v. R.E. CHATHAM.

Played at Chatham on Saturday, November 11th. Guy's had three of their regular team absent for this match against the R.E.'s, who are one of the strongest sides in the South.

The R.E.'s started strongly and were soon attacking, but for a long time the Hospital defence held out against combined pressure, but eventually the R.E.'s scored. The home side continued to have the best of the game, but Guy's made a few attacks on the R.E. goal, from one of which Schollum scored, but was ruled offside. Half-time came with the score 1—0.

The R.E.'s continued to press in the second half and scored 5 more goals, the last 3 in the last 10 minutes of the game. Although the score of 6—0 against the Hospital sounds somewhat large, it must be remembered that the R.E.'s had inflicted on Cambridge University, three days before, their first defeat since December, 1920.

The Guy's defence played a magnificent game, especially Graham-Bonnalie at back, Dunnill in goal and Slater at centre half. The forwards were rather ineffective against the sound and speedy R.E. defence.

Guy's Team.—Dunnill, Bowen, Graham-Bonnalie, Hooper, Slater, Coneybeare, Hunt, Broido, Schollum, Eglington, Owen.

Cricket.

At the Annual General Meeting of the Cricket Club, held on October 30th, 1922, the following officers were elected for 1923:—

President—Prof. T. B. Johnston.

Captain—G. D. Shaw.

Vice-Captain—J. G. Van Schalkwijk.

Hon. Secretary and Treasurer—L. S. Williams.

Committee—Messrs. C. Arkles, A. G. Ensor, N. H. Saint, T. Wooldridge.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

VOL. XXXVI., No. 898.] DECEMBER 9, 1922. [NINEPENCE.

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Passim.

EXTRACT from a daily paper, with no abnormal physical signs in its circulation—

> "The Southwark Guardians have joined the misguided little band of minor public bodies, who are doing their utmost to obstruct the efforts of the health authorities to stamp out the small-pox outbreak. With a fine disregard for the interests of the people under their care, they have refused to allow particulars of local vaccination centres to be circularised in their district. In addition, they have refused permission for the children, adopted by them and housed at the Central London District Schools, to be vaccinated."

Now, isn't that a pity! After all the money that has been spent on educating the public, to enable them to take an intelligent interest in just such modern scientific manœuvres as vaccination and after all the careful consideration of the subject and the study of the small-pox statistics that that minor public body must have devoted to it, isn't it a pity that the Southwark Guardians should have formed such a poor opinion of the prophylactic value of vaccines. Of the cases of small-pox reported this year, and they number well over eight hundred, over seventy-five per cent. have occurred in people who have never submitted themselves to the kindly cruelty of the lancet. Surely the minor P.B. must see more than a mere co-incidence in that, or does it draw logical conclusions from erroneous data? There are certainly many quaint ideas circulating in the Borough at the moment. The father of a large and increasing family confided to an Extern recently that he could see no reason at all why we should want a King and that everybody knew that Mr. Lloyd George was a German. He was quite a nice man, kindly, good-natured, fond of his home, and supremely confident in the skill of the "doctor," and yet one of the articles of his belief was that the late Prime Minister was a German. Only cries of "Doctor, baby's here," prevented a Whig extern from doing a little missionary work on behalf of the National Liberals. We have an idea, not our own, for dealing with this kind of mis-information, of which more will be heard in a succeeding number of the GAZETTE.

AT the moment we are not concerned with matters of calf-lymph and naturalisation, being all agog with preparations for another Christmas. Oh happiest of all festivals, observed in Hospital! Already our right index finger is septic through clumsy wire-work in making an artistic lamp-shade for the ward, and we read

our "Synopsis of Surgery" to the lilting refrain of "Sweet Hortense," emanating from the College green-room. The "Niggers" this year surely will be fit to beat the band. Such quaint noises issue from their practice room that we realise that the Hospital Musical Society has not become extinct, but has merely changed its name. Under their new President and Vice-President, Messrs. A. T. Rogers and W. R. Carling, to whom we offer hearty congratulation on their appointments, the Residents will this year worthily uphold the traditions of past, grotesque and cosmopolitan "Niggers."

An old member of the Hospital, Dr. W. A. Phillips, has presented to the Wills Library a book of great interest at the moment, and one for which we are very grateful. "The History and Practice of Vaccination" was written by James Moore, Director of the National Vaccine Establishment, in 1817, and contains a very interesting report of Jenner's original experiments, leading up to his great discovery, by means of which England was made free of the dread scourge of small-pox. It also recounts the difficulties with which he had to contend in persuading both a large number of medical men and a larger number of the public to give a reasonable trial to his scheme. The book arrived too late for a full review to be published in this number, but, on opening it at random, we have happened on statements of considerable interest. Here is one: "Medical differences are proverbial, and sometimes prompt rivals mutually to insinuate that each have poisoned their patients." What bad, old days, to be sure. Looking back from to-day, when all doctors are brothers and the profession, as a whole, almost communistic, patients are hardly ever poisoned even by students "running the Front," and then quite by accident. Dr. Rowley was one of the chief antagonists of Jenner, and used to give illuminating clinical lectures on vaccination. On one occasion "he introduced a poor boy, whose face was swollen and much disfigured by a large abscess. He requested his auditors to inspect closely this unparalleled case. 'On his cheek you plainly perceive a protuberance arising, like a sprouting horn; another corresponding one will shortly spring up upon the other side; for the boy is gradually losing the human lineaments, and his countenance is transmuting into the visage of a cow.'" What an opportunity for discussion such a case would provide at a Clinical Evening of the Physical Society.

The accounts of the City and Hospitals' Charity Athletic Contest, held at Honor Oak Park in September, have just been published and show a most excellent credit balance of one hundred and fifty-four pounds. This was far greater than was expected, and the five hospitals of the United Hospitals' Athletic Club are the richer by thirty pounds each. The value of the tickets sold at Guy's was over twice that taken by the other four hospitals together.

Does the Hospital boast a branch of the Cyclists' Union? If so, now is the time for them to act. The L.C.C. have decreed that the lately-erected bicycle shed must be demolished, as it is less than twenty feet from the centre of the road-way and is in advance of the main line of frontage of our buildings. We have no selfish motives in suggesting opposition to this monstrous violation of our home, being unable to afford the upkeep of a motor cycle and unable to keep up on an ordinary one. The tosses that we took, when compelled at the stern call of duty to skid down Long Lane, turned a pleasant month into an unfading nightmare. Having explained our position, we urge students to fix their cycling club badges firmly

into their caps and to see what can be done about it. The shed is within our own garden wall and no twenty-foot vehicle, however far it wandered from the centre of the roadway, could be incommoded by the shed without first climbing into the Hospital. With the exception of one recently abandoned mascot on the medical side, no vehicle has yet been known to do this. And yet, we suppose, the L.C.C. will have their way. Not their's to make reply, not their's to reason why, their's but to do and die, while all the world, or at any rate that part of it who are owner-riders of bicycles at the Hospital, wonder.

THE sympathy of the entire Hospital will be extended to Dr. Ryle in his bereavement on the death of his father in Naaman. A student at the Hospital in 1880, Reginald John Ryle became a house-surgeon and eventually Honorary Surgeon at the Sussex Eye Hospital. After 40 years of medical practice he passed away peacefully in his old hospital on December 4th, 1922.

A fuller obituary notice will appear in our next issue.

IT is with the greatest regret that we record the death of Dr. James Andrews, at Hampstead, on November 17th, 1922. One of the oldest Guy's men, he entered the Hospital as a student in 1848, at a time when Aston Key, Addison and Bright were all active members of the Hospital Staff.

Dr. Andrews' reminiscences of the time when St. Thomas's Hospital occupied its original site opposite Guy's are of the greatest interest, and we have pleasure in publishing them on page 491. He remained in active practice till his retirement at the age of 80. His two sons and a grandson are also Guy's men.

Reminiscences.

BY THE LATE JAMES ANDREWS, M.D.

I entered at Guy's Hospital in October, 1848, having been largely influenced in my choice of a hospital by the fame of Mr. Aston Key. Key was at the height of his career and when he operated the theatre was crowded by visitors from London and the provinces. He was a brilliant and rapid operator, and it was a proverbial saying that he "could do a lithotomy while you winked an eye."

Key was an autocrat who tolerated no contradiction and but little argument. Hence his relations with his colleagues were often strained and with Dr. Addison, another strong personality, resulted in a total cessation of intercourse. The traditional breakfasts to his dressers were marked by frugality and their duration was cut short by the intimation that "it was time to go to the Hospital."

Key died of cholera in my second year after an illness of forty-eight hours, and I remember that I happened to carry his umbrella when he visited the wards the day before he was taken ill.

When I was a student, St. Thomas' Hospital, a foundation older than Guy's, occupied its original site. The building was imposing with a fine main entrance in Borough High Street, and a working entrance in St. Thomas' Street. I believe the iron gates of the latter are still standing.

By an arrangement between the two hospitals the students of one might visit the wards of the other for clinical instruction. I went over to St. Thomas' occasionally and remember Mr. Solly, a surgeon, and Dr. Waller, the obstetric physician, as notable teachers.

There was sharp competition between the hospitals for accident cases and the rival students would keep watch in St. Thomas' Street—when a police constable brought a case into Guy's they would reward him with beer from the dressers room.

The Guy's School was much the larger with an annual entry of some forty or fifty students as against about a dozen at St. Thomas'.

Anatomy lectures were delivered every day by Mr. Hilton at two o'clock, and the lecturer was as fine an anatomist as he was a surgeon. The old dissecting room was near the King Street gate on the West side of the road, but it was soon after moved to another site. Demonstrations were given every morning at nine o'clock by Poland, Birkett and Callaway. Poland was the ablest of the three and a great favourite with the students.

The teaching of anatomy was excellent and students had the subject well driven home.

Physiological lectures were by Dr. Gull at ten o'clock. There was little apparatus and no microscopical demonstrations though a certain number of mounted specimens were available in the Museum.

Dr. Taylor, the great toxicologist lectured on Medical Jurisprudence. Botany lectures were chiefly remarkable for the extreme noise and rowdiness of the students. No prizes were offered and a frequent saying of Gull's was "the only prizes we give are more opportunities for work."

My first clinical appointment was as clerk to Dr. Barlow and subsequently I clerked for Dr. Golding Bird and Dr. Hughes. The last was an accomplished and wise physician, and ever a kindly friend to me. A large number of qualified men always accompanied him on his visits to the wards. He was a bachelor and lived in St. Thomas' Street.

I often heard Sir Samuel Wilks express his regret that he had never edited and re-published Hughes' book on Diseases of the Chest.

Golding Bird was a scientific pharmacologist and always interested in new remedies. He drove a pair of fine horses and lived in Myddleton Square.

I held no appointment under Dr. Addison. He was a man of fine presence and imperious manner, and was greatly absorbed in his classical investigations.

A great deal of valuable teaching was given by Mr. Stocker, the apothecary to the Hospital. He was a qualified man and used to go round the wards between ten and eleven p.m. No treatment of patients took place, but the clinic was a most useful experience.

I have already referred to Dr. Gull as lecturer on physiology. At this time he had not become Assistant Physician, but he already exercised considerable influence in the Hospital, and regulated all the student appointments. Poor indeed were the prospects of a student if he were not persona grata with Gull, who exercised powers now vested in the Dean. He lived in the house at the west corner of the first court with a door opening into St. Thomas' Street.

Passing to surgical work I have a very vivid recollection of Mr. Hilton as an excellent teacher and accomplished surgeon. He took a special interest in the treatment of aneurysms by digital pressure, but in many cases this measure failed and amputation was resorted to. Hilton was a clean and neat operator, but for some reason his results were not very satisfactory. In contrast with this Mr. Cock was a slower and more clumsy operator but frequently obtained better results.

Owing to the tension between Mr. Key and Dr. Addison, Mr. Hilton did all the surgical treatment of the latter's patients.

The Clinical Building, recently demolished, was originally used for lunatics, and was under the care of Dr. Gull. No students were admitted to these wards.

Venereal cases occupied the wards at the top of the old building—one ward was called Patience. The patients were crowded together and the methods of examination were far from edifying.

The Senior Porter was named Archer and was an imposing official. When any member of the Staff arrived Archer took an iron sheet and struck the corner of the wall, calling out the name of the physician or surgeon that it might be heard by students in the old library on the right of the Colonnade.

I obtained my appointment as dresser in my third year, six months before going up for examination and considered myself lucky in being allotted to Mr. Bransby Cooper, the Senior Surgeon. I am not sure that my friendship with his son, a fellow student, may not have had something to do with my appointment. Bransby Cooper, who had lost an eye in Egypt, was a hasty, excitable man always well dressed and lived in Spring Gardens, Trafalgar Square, then a favourite locality with consultants. He was on intimate terms of friendship with Sir Benjamin Brodie and used frequently to visit at his house to debate surgical questions.

The dressership was for six months and each surgeon had four dressers who took it in turn to "take in" and reside in the Hospital. The dresser continued in the Hospital for the fortnight after he ceased to be dresser for the week, so that three dressers representing the three surgeons were always in residence. The dresser for the week sat at the head of the dinner table; there was no house-surgeon.

It was the established custom that he should provide an elaborate dessert, which, when the residents were called away, often became the prey of casual visitors. The dessert was furnished by the Head Porter at extortionate prices which were an onerous expense to the students of narrow means. After my dressership was over, I and other men took measures to put an end to this undesirable monopoly.

Cooper was an exceedingly rapid operator and would cut into a hernial sac with one stroke of the knife. (It must be remembered that anæsthetics did not come into use until after my hospital days had ended). He was very annoyed if anything went wrong during an operation or if a dresser were slow. Should the luckless assistant fail to pick up an artery Cooper would thrust

him away, often pushing a blood stained hand on a white shirt front. This was trying as dressers always appeared at operations in their best clothes.

Although he was a successful lithotomist Cooper once had a patient die on the table and this was made the occasion of an attack on the surgeon by the Editor of the *Lancet*.

My chief frequently took a dresser with him to private operations, and I remember that I earned my first fee of a guinea by assisting at a Symes' amputation.

I have a vivid recollection of a case which is interesting as a contrast between past and present methods of treatment. Bransby Cooper went down to a place near Chelmsford to see a tenant of the Hospital who had fallen off his horse and sustained concussion of the brain. A dislocation of the hip joint had escaped notice and remained undiagnosed for several weeks. Cooper induced the patient to come in to Guy's and persistent efforts with pulleys were made to reduce the dislocation but without effect. As a result the ligaments of the knee were damaged and there was great swelling. Sir Benjamin Brodie was now brought in to see the patient and advised that as the head of the femur had found a new socket on the dorsum ilii nothing further should be done. I was sent down to Chelmsford in charge of the patient, but received no fee for my trouble, nor, I think, did Bransby Cooper.

As dressers we were fortunate to have the help and advice of "Governor" Hills, the cupper to the Hospital. A considerable amount of cupping was still done in the wards, but this official, though unqualified, was a man of great and wide experience. Always nicely dressed, with a benevolent face and unassuming manner, Hills was an admirable adviser and friend.

The Gynæcological wards were in Petersham House near the late Clinical Building. Dr. Lever was the Senior Obstetric Physician and Dr. Oldham the Junior. Both saw out-patients.

Lever had an enormous practice and drove a pair of thoroughbred bays, always having a second pair brought up to his house in High Street, Borough, that he might change horses without delay.

As extern I attended a hundred cases though at that time six was the compulsory number. There were twelve externs and each was on duty for two hours in the twenty-four.

After I was qualified I became Resident Obstetric, an appointment then considered the highest attainable.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—The official side of the new curriculum is being pressed forward by the Medical Council. I wish it were possible to interest General Medical Practitioners, Teachers and Students in these proposals and not leave them to the Elect. I am strongly opposed to them. For one reason the arduous career of a son is too long—half of a lifetime—and not worth the parent's expense. The first two years are misspent. Sir W. Arbuthnot Lane daringly suggests logic and mechanics. Sir Charters Symonds has spoken in his Hunterian lecture—the best treatise on the subject—of a student joining hospital with his bright intellect and fresh enthusiasm, and after two or three years of theory, entering the wards, jaded and weary. Some of the subjects might be scrapped, e.g., biology and others, practically applied anatomy and physiology, and hasten the days of clinical work. Think of the shock to the Olympian Dons, if they found physiology taught interestingly at the bedside.

Elsewhere, for a nonce, I hazarded Homer's "Odyssey, Goethe's "Wilhelm Meister," and Carlyle's "French Revolution," for the preliminary, to prevent turning out mere medical machines. The materialistic tendency in medicine (inevitable) never more needed the humanities, and I would cast a vote for a "matriculation on the classical side." Be that as it may, we are at the parting of the ways. A vital change might have been achieved. I hope Sir W. Arbuthnot Lane and Sir Charters Symonds will have the courage of their convictions and defeat the present arid policy of the Medical Council.

RICHARD GILLBARD.

Willesden Green.
December 4th, 1922.

Papers by Guy's Men.

Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S., and Others. Discussion on the Treatment of Non-Malignant Affections of the Colon.—*Brit. Med. Jour.*, ii., 1922, p. 1014.

A. R. Thompson, Ch.M., F.R.C.S. Hæmaturia.—*Clinical Journal*, li., 1922, p. 553.

H. C. Cameron, M.D., F.R.C.S. Common Errors in Diagnosis in Regard to Children's Ailments.—*Clinical Jour.*, li., 1922, p. 565.

An Unusual Case of Appendicitis.

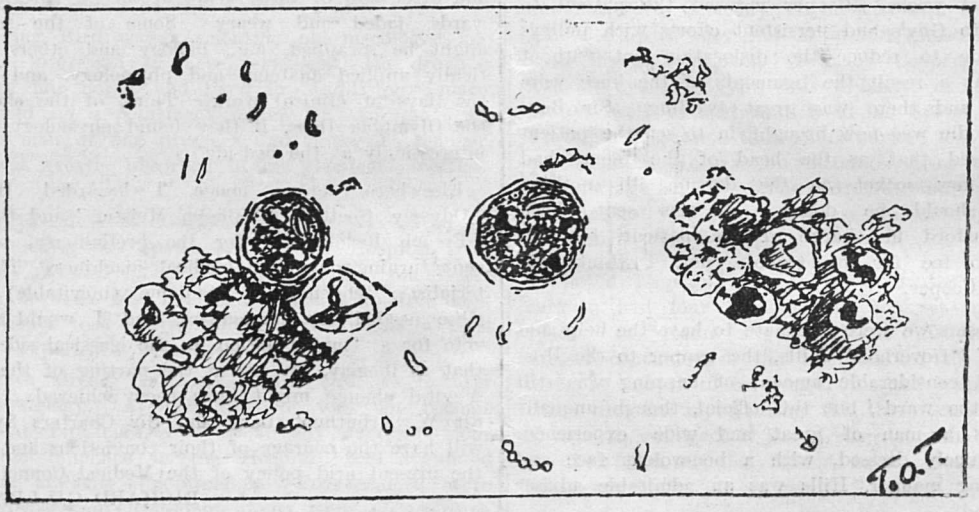
Private A., aged 19 years, was admitted to the British Station Hospital, Secunderabad, complaining of fever and some abdominal pain. Unfortunately before I saw him he had been given Ol. Ricini. His temperature was 102·8 and pulse 80. He was admitted at about 8 o'clock in the evening and seen by me at about 12. He had walked up to the hospital.

He complained of fairly acute pain localised in the right iliac fossa and the abdomen was moderately rigid. On palpation marked tenderness was noticed over the right iliac fossa. His tongue was dirty. His pulse was of good volume and regular.

I diagnosed appendicitis, but as his temperature and pulse were inclined to come down, then being rose to 102. A flatus tube was passed and drachm doses of oil of cinamon in water were given with some relief. He was given morphia, grs. $\frac{1}{4}$, at 9.30, and had a fair night, but in the early morning his bowels were open five times.

Seen at 8.30 his temperature had risen to 103, and pulse was of good volume and regular and 76 to the minute. He was complaining of abdominal distension, but on examination the abdomen was found to be quite flaccid and there was no sign of peritonitis. The stools were sent to the laboratory for examination and a report was returned that evening that entamœba hystolytica and blood were present. Emetine, grs. $\frac{1}{2}$, and morphia, grs. $\frac{1}{4}$, were given hypodermically and the patient passed a very good night.

Next morning I found him sitting propped up in the Fowler position, reading a paper and quite free from pain with a temperature of 99. Emetine grs. 1 per diem, were continued for twelve days and he made a complete recovery.



E. Histolytica from Scraping from Appendix. Date-stone Impaction Case.

101·8 and 76 respectively, I decided to have him watched, and any change reported to me.

I saw him again at 7 o'clock and his condition was more acute. His temperature had risen to 103, pulse 84, and the abdomen was very rigid. His bowels had been open.

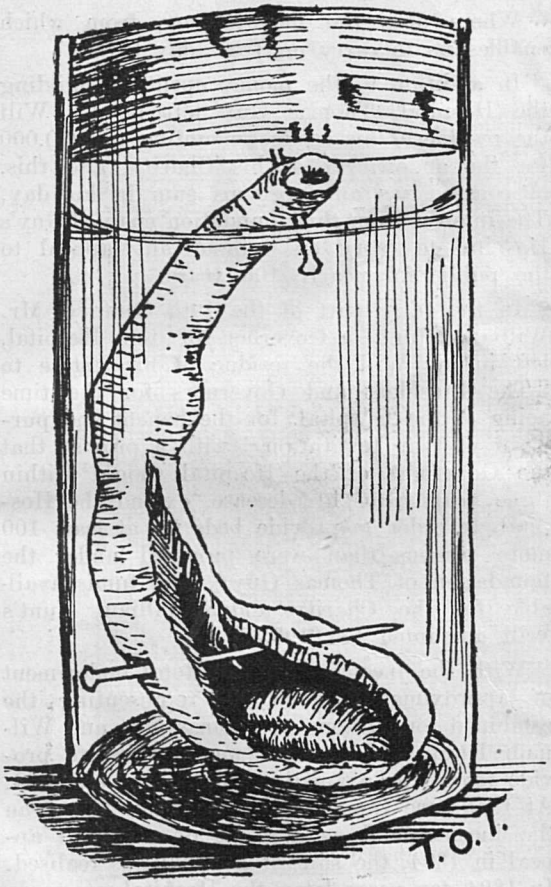
I decided to operate at once. The rectus incision was made and on opening the peritoneum the appendix presented at the wound. It was greatly enlarged and was gangrenous at the end. It was removed and as there was no sign of peritonitis the abdomen was closed.

He complained of a good deal of flatulence and abdominal distension that evening and the temperature, which had dropped to 101 after the operation,

I had kept the appendix unopened in spirit and it struck me that perhaps I might find entamœbæ hystolytica in the appendix so I opened it and to my astonishment found a date stone impacted in the end which had evidently caused the gangrenous appendicitis. I then took a scraping of the stone and on examination under the microscope entamœbæ were found.

I then asked the patient if he had been in the habit of eating fruit and he stated that he had been accustomed to buy oranges and bananas from a fruit hawker, and on asking if he had eaten any other fruit he stated that thirty-six hours before coming into hospital he had bought some dates from this man and had eaten them, but he did not remember having swallowed a stone.

This case appears interesting for more than one reason. First it was very lucky that the diagnosis of appendicitis was made before the bacteriological report of dysentry was returned, as otherwise the acute condition might have been missed until perforation had occurred as I have on several occasions seen cases of amœbic dysentry simulating acute appendicitis and on one occasion it so simulated it that after consulting with three others, I operated and found a normal appendix and next day amœbæ were found in the stools.



DATE-STONE IMPACTED IN APPENDIX AND E. HISTOLYTICA PRESENT.

Secondly, one has continually heard it stated, and it is a very general idea in the lay mind that appendicitis is caused by impaction of a pip or stone, but I have never actually seen it before.

Thirdly, that the eating of dates, which of all fruits in the east are most liable to infection, should have caused both the dysentery and the appendicitis.

In conclusion, my thanks are due to Colonel Jack Powell, D.S.O., commanding the British Station Hospital, Secunderabad, for permission to publish this case and to Captain T. O. Thompson, R.A.M.C., for the bacteriological examination and for supplying the two drawings, one of the appendix with the stone in situ (natural size) and one of the slide of the scraping from the stone.

D. C. SCOTT, Captain, R.A.M.C.

Specialities.

We have received from Cadbury Bros., Ltd., a package containing a tin of Bournville Cocoa and an assortment of chocolates. We desire to express our thanks to the firm, the quality of whose products, judging from the samples sent to us, leaves nothing to be desired.

J. BRUCE, Lamp Merchant, 232, Borough High Street, S.E.1.

A good reading Lamp has its advantages and is still preferred by many people to the ordinary Gas and Electric Lamps.

To all such readers the "Guy's" Students' Reading Lamp may be safely recommended. It is nickel plated, of good design, fitted withh a powerful reflector, and is very effective.

Safety is one of its good points, for should it by chance, be overturned when in use, it is automatically extinguished. The price is very moderate, and includes free delivery to any address in the Kingdom.

Pass List.

In the Pass List of the Final L.D.S. Examination published in our last issue, there was no explanation as to the meaning of the asterisk against several names. The names marked thus * have passed Part I. only, and the remainder have now completed the examination.

Change of Address.

Dr. W. J. Henson, 1, Albemarle Street, W.1. ('Phone Mayfair 1415).

H. Neish Purdom, L.D.S., R.C.S., Eng., Loxford, 75, Park Lane, Croydon.

Capt. G. D. Gripper, R.A.M.C., Walpole House, Wallington, Surrey.

E. D. Scott, M.D., M.R.C.P., 141, Marine Parade, Brighton.

D. Oliver Richard, M.B., B.S., c/o Director of the Medical Department, Khartum, Sudan.

Guy's Hospital.

Where the Money comes from and where it goes.

(Abstract of an Address given by the Superintendent to the Guy's Hospital Employees' Association at Guy's Hospital, October 30th, 1922. Dr. Fawcett in the Chair.)

Ladies and Gentlemen,

All of us here this afternoon are working in our own way and in our own departments for the benefit of the Hospital built by Thomas Guy.

You should know that it is nearly 200 years now since he founded his Hospital, the legal description of which is the "Hospital founded at the sole costs and charges of Thomas Guy, Esquire."

The purposes for which the Hospital was built are set out in Guy's Will dated September, 1724, in the following words :—

"And my mind and will is, that until such incorporation, by letters patent, or Act of Parliament, as hereinafter directed, can be obtained and take effect, they my said Executors and last mentioned Trustees, their heirs,executors, administrators and Assigns; and afterwards such Corporation shall and do, out of the *Residuum* of my Estate, or the rents, interest, or other profits thereof, carry on, erect, finish, and fit up the two new Squares of Building in *Southwark*, by me some time since began and intended for an Hospital, for the reception of such sick Persons as are herein after mentioned; and such other erections, offices, and Buildings, as shall, in the opinion of my said Executors and Trustees, be for that purpose further necessary; and also provide and furnish the same with beds and all other conveniences for the reception of, and receive and entertain therein, four hundred poor persons and upwards labouring under any distempers, infirmities or disorders thought capable of relief by Physic or Surgery."

You may remember that Thomas Guy lived to see his Hospital built, but that five or six days before it was opened for the reception of the first patient, he died. He is buried, and sleeps his eternal sleep, in the Crypt underneath the altar in the Chapel in the Quadrangle, which you all know.

Two hundred years have gone by, and this Hospital is still open for those persons for whom Thomas Guy made his immortal foundation.

If a person is poor and sick, he is entitled to come into the Hospital free of charge. I think at the present day Guy's is almost the only Hospital left in London where no charge is made to any in-patient for maintenance.

Where does the money come from which enables us to carry on from day to day?

In addition to the money spent on building the Hospital, Thomas Guy left by his Will the residue of his estate, amounting to £220,000 for the endowment of his Charity, and this, of course, was an enormous sum in his day. The interest from this foundation enabled Guy's Hospital to carry on without any appeal to the public for nearly 100 years.

In the early part of the 19th Century, Mr. William Hunt, a Governor of the Hospital, left in his Will the residue of his Estate to "The President and Governors for the time being of the Hospital, for the benefit and purposes of that Institution," with a proviso that the Governors of the Hospital should within three years after his decease, extend the Hospital, in order to provide beds for at least 100 more persons than were provided under the foundation of Thomas Guy. The funds available for the Charity under William Hunt's Will amounted to £193,390.

With the income from the total endowment of approximately £400,000, representing the combined foundations of Thomas Guy and William Hunt, the Hospital was enabled to provide for all its expenditure until the year 1884. At that time the expenditure began to outrun the income, and as a result of a special appeal in 1884, the sum of £20,000 was realised. In 1894, ten years later, the Hospital was again getting into debt, and the Re-Endowment Fund, which still exists, was called into being, principally as the result of the efforts of two persons. Guy's owes more to these two persons, who are still happily alive, and with us, than to anyone since the time of Guy or Hunt—I refer to Mr. Cosmo Bonsor and Sir Alfred Fripp.

King Edward VII., then Prince of Wales, at their request consented to become Chairman

of the Re-Endowment Fund and to take the Chair at a Public Dinner. At the Dinner it was announced that more than £114,000 had been already given or promised.

In the course of a few years the Re-Endowment Fund reached £225,000, and by last year it had amounted to over £446,000, so that with Thomas Guy's and William Hunt's money, together with the Re-Endowment Fund, our Capital at the present time stands at just a little over £900,000.

The income from that capital is, at 6 per cent., a little over £50,000 a year. That £50,000 a year is our only assured income.

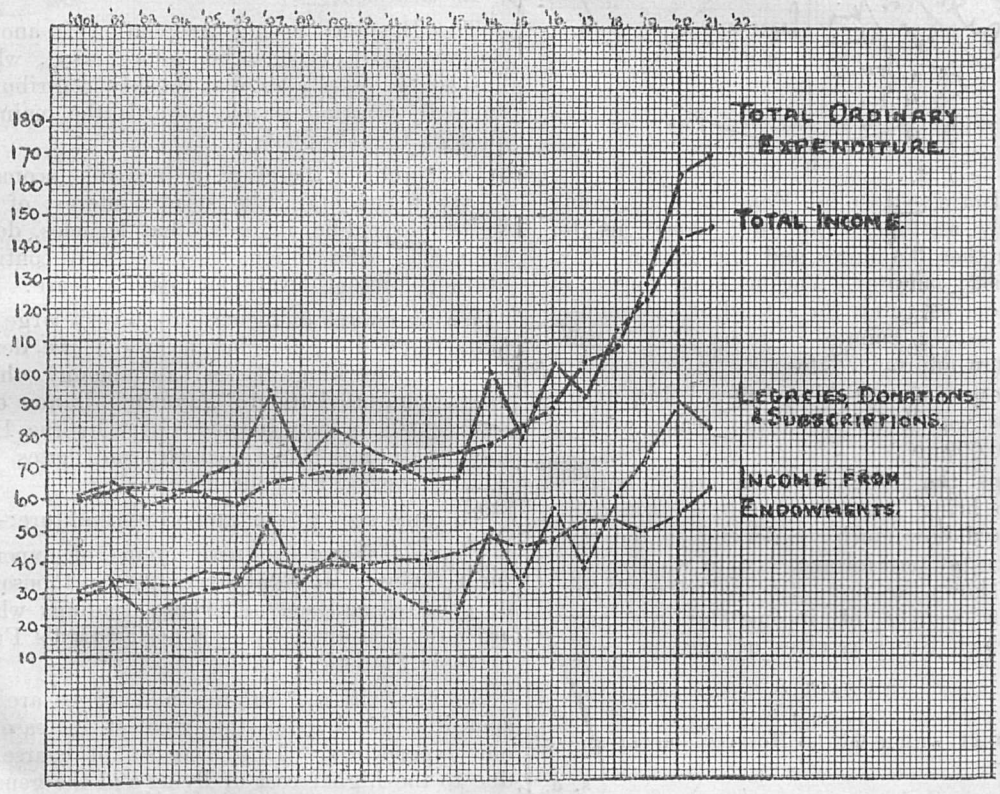
Our expenditure last year was £169,000. Where does the rest of the money come from?

Chart 1 shows the Income and Expenditure of Guy's Hospital since 1901 in thousands of pounds. You will notice that the total Income and Expenditure have been steadily going up, much more rapidly since the War, and you will also notice that, until 1918, the total Income on the average was always a little more than the Expenditure, so that we were enabled to keep going and to keep the Hospital up to date, both structurally and in the development of its various departments.

Since 1918 the Expenditure has outrun the Income, and the problem before us at the present day is to see how in the near future we can equalise our in-comings and our out-goings.

CHART 1.

INCOME AND EXPENDITURE SINCE 1901 (in thousands of pounds).

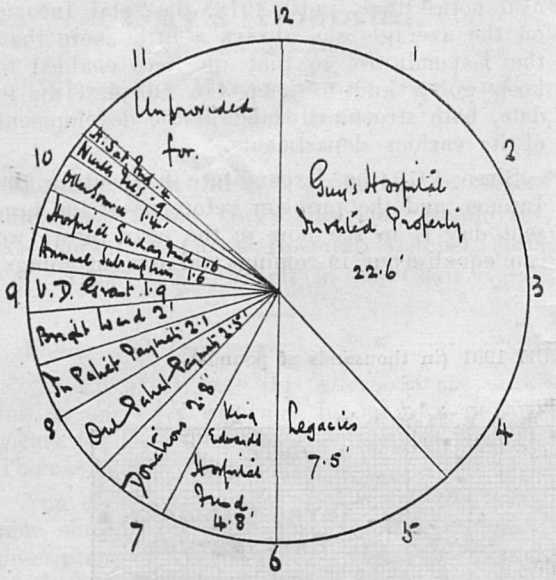


To bring home to you in diagrammatic form how the Hospital is kept going—

Chart 2 represents a clock face, showing the period in every hour for which Guy's Hospital is provided from the various sources of our income.

In 1921 the Income from our Invested Property kept us going for just over 22½ minutes in every hour, and Legacies for 7½ minutes.

CHART 2



King Edward's Hospital Fund kept us going for nearly another 5 minutes, Donations for nearly another 3 minutes, and Out-Patient Payments for 2½ minutes. Various other sources of income kept us going for a total of 52½ minutes but the last 7½ minutes of every hour, day and night, were unprovided for.

The result of that 7½ minutes being unprovided for was a deficit on the year's work of over £20,000.

Perhaps the following diagram (Chart 3) will also bring home to you in a form easily remembered how much we depend on the various sources of our income, and to what extent. Chart 3 shows the proportion contributed from our main sources of income towards every pound which Guy's receives as Income :—

CHART 3.

IN 1921.

OF EVERY £1 WHICH GUY'S HOSPITAL RECEIVED AS INCOME :—

	s.	d.
Guy's Hospital Invested Property, contributed ...	8	11
Legacies ... ... " ...	2	11
King Edward's Hospital Fund ... " ...	1	8
Donations ... ... " ...	1	1
Out-Patients' Payments ... " ...	1	0
In-Patients' Payments ... " ...	0	10
Bright Ward ... ... " ...	0	10
V.D. Grant ... ... " ...	0	9
Hospital Sunday Fund. ... " ...	0	8
Annual Subscriptions ... ... " ...	0	7
Nurses' Fees for Training ... " ...	0	4
Hospital Saturday Fund ... " ...	0	2
All other Sources ... ... " ...	0	3

In the present financial crisis through which all the Hospitals in England are passing, efforts are being made to increase the income of the hospitals by schemes which will embrace in their activities all wage earners, who will contribute a small sum weekly.

As you know, we at Guy's make no charge for the maintenance of patients, but we invite all patients, *after* treatment, to contribute according to their means. In-Patients' payments, which now stand at 10d. out of every £1, will probably increase, particularly in view of the fact that certain Insurance and Friendly Societies are now making a contribution on behalf of their members who have received hospital treatment.

The Hospital Saving Association is another Society which is now being organised, which has for its aim a regular weekly contribution from all working people towards the maintenance of the Hospitals.

Our problem, therefore, as regards income is to try to maintain the steady interest of the well-to-do public, in order that legacies, donations, and subscriptions may not only continue at their present level, but may increase.

We also want to increase to a very large extent, if possible, the income which we derive from the working classes, an amount which, apart from the Patients' Payments, is now only represented in our Income Chart by the Hospital Saturday Fund, which contributes but 2d. for every £1 of our income.

To come now to our annual expenditure:—

Chart 4 shows the main items of expenditure of Guy's Hospital since 1900 in thousands of pounds, analysed under the headings which are published annually by King Edward's Fund in their Statistical Tables.

As you will see, salaries and wages are responsible for by far the greatest increase in our expenditure. This increase, of course, is due to the higher cost of living and the general enhancement of salaries and wages, including those of the Nursing Staff.

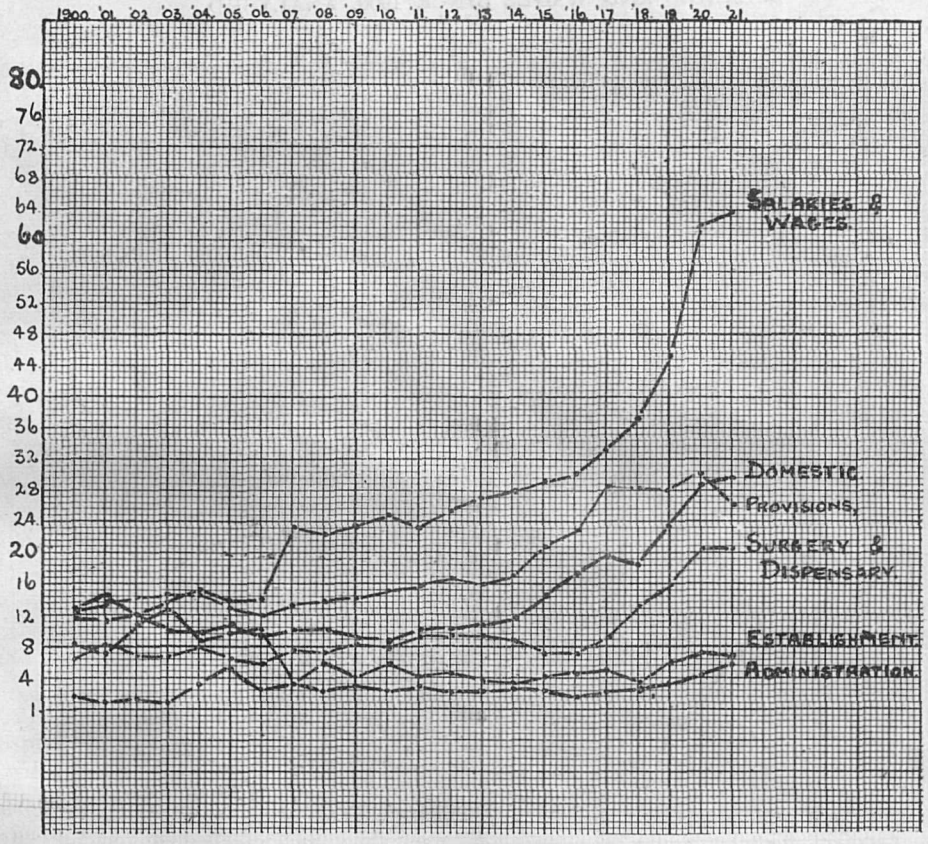
Chart 5 is a further analysis of salaries and wages. The curve indicating *Mechanics Wages* refers to all the workmen employed in the Hospital, and it may interest you to know a few details as to the staff which the Hospital employs for the general purposes of renovation and repair, the manufacture of bedding, instruments and appliances which we make at

Guy's, and which most other Hospitals buy outside :—

11 Carpenters, 3 apprentices.
2 Upholsterers, 1 assistant.
6 Bricklayers, 1 apprentice.
2 Plasterers, 1 apprentice.
2 Orthopædic Workers, 1 apprentice, 1 assistant.
1 Baker.
1 Cutler.
10 Wardmen.
4 Engine Drivers.
5 Stokers.

CHART 4.

MAIN ITEMS OF EXPENDITURE SINCE 1900 (in thousands of pounds).



2 Plumbers, 1 apprentice, 2 plumbers' mates.
3 Coppersmiths, 1 apprentice, 1 assistant.
5 Electricians, 2 apprentices, 1 assistant.
7 Fitters, 1 apprentice, 6 mates.
1 Blacksmith, 1 mate.
24 Painters; 1 Writer; 2 Window Cleaners.
20 Labourers.
3 Strong Room Attendants.
2 Laundrymen.
1 Gateman.

Total in Works Department 139.

Nursing salaries have increased, not only because of an increase in the actual salaries of Nurses, but because the shortening of Nurses' hours of duty, in response to the popular demand, means that more nurses must be employed.

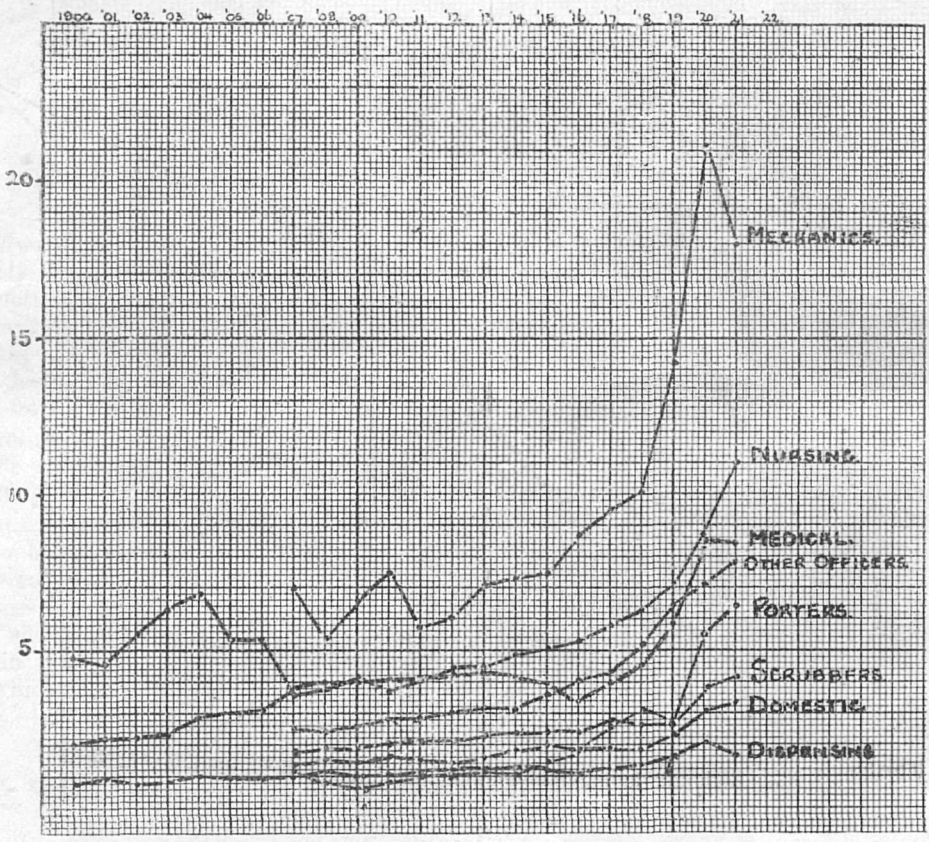
A reduction of our Nurses' hours of duty to a 56 hour week means that we have to increase our staff of Nurses by no less than 60. This increase in the number of Nurses necessitates increased accommodation, and this has involved the Hospital in recent years in a heavy capital expenditure for this purpose. It also involves more domestic servants for the care of the additional Nurses' quarters, and the additional Wardmaids will require additional housing accommodation. Added to this there will, of course, be for the Hospital the additional cost of the maintenance of the Nursing and Domestic staff, and the upkeep of the additional accommodation which it has been necessary to provide.

It may interest you to know that the Nursing Staff consists of the following :—Sisters 42, Nurses and Pupils 264, Massage and Electrical Assistants, Radiographers and Photographers 12, Domestic Staff 107, Laundrymaids 32, Sewing Room Maids 9, Scrubbers 47, making a total of 513 women, who have to be housed on the Hospital premises, in order that a daily average of approximately 550 patients may be looked after.

In addition to the Nursing Staff there is a Female Administrative Staff numbering 25.

CHART 5.

SALARIES AND WAGES SINCE 1900, ANALYSED.



The *Medical Staff*, whose salaries are shown on the Chart, include 53 Members of the Visiting Staff, of whom 25 are unpaid, 30 Registrars and Assistants, and 22 Resident Officers who are unpaid, but receive quarters and board.

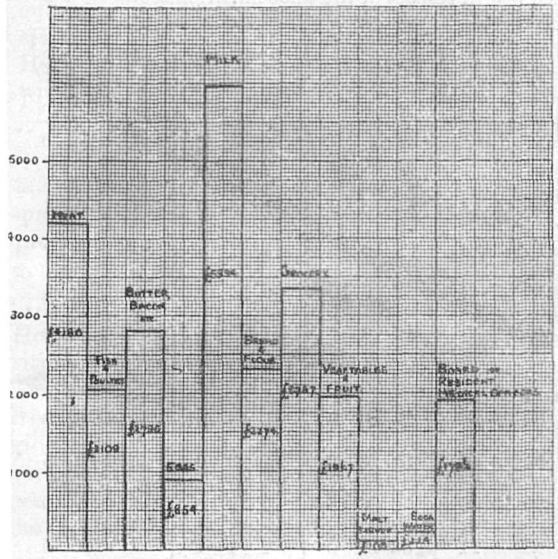
Under the heading *Other Officers* on the Chart are included the Assistant Matron, Administrative and Departmental Sisters, House-

keepers, the Matron's Office Staff, the Superintendent, the Chaplain, the Superintendent's Office Staff, the Lady Almoner and her Staff, the Surveyor, the Consulting Engineer, and other male and female administrative staff, making a total of 49 in all.

Porters' Wages show a large increase during the last year or two. This is owing largely to the fact that porters now work only 8 hours a day, and the number of porters required for the service of the Hospital has, therefore, been considerably increased.

CHART 6.

ANALYSIS OF COST OF MAINTENANCE.



The 27 porters required for the service of the Hospital now cost £6,500 a year, as compared with just under £3,000 a year 15 years ago.

The next main item in Hospital expenditure is *Maintenance*, or the cost of Provisions and Food for the Patients.

Chart 6 gives an analysis of the cost of Maintenance during the year 1921.

It will be seen that Milk is by far the heaviest item, costing little less than £6,000 a year Meat and Groceries are also very heavy charges, but generally speaking the cost of provisions has been steadily on the down grade during the past 12 months, and this diminution in cost is responsible, as you know, for a considerable proportion of the diminution in the cost of living. It is probable that in the year 1920 we reached the high tide in the cost of provisions.

CHART 7.

SURGERY AND DISPENSARY.

		£	s.	d.
1.	Drugs, Chemicals, Disinfectants, etc.	8,074	6	10
2.	Dressings, Bandages, etc.	5,212	8	7
3.	Instruments and Appliances ...	5,536	13	4
4.	Wines and Spirits...	436	3	7
5.	Sundries...	1,162	15	3
		20,422	7	7

Surgery and Dispensary.—Of the £20,000 spent on Surgery and Dispensary, drugs, chemicals, disinfectants, dressings, and bandages cost a little over £13,000. Towards the cost of drugs and dressing, the Out-Patient payment of 6d. a head produced £7,338 7s. 2d., so that the patients' contributions do constitute a very considerable proportion of income, which may be set off against the cost of drugs and dressings. Instruments and appliances cost over £5,500. Wines and spirits, which are included under the heading "Surgery and Dispensary," in the Hospital, only cost £436—a very striking instance of the diminution in the use of alcohol for therapeutic purposes during the last 20 to 30 years.

Domestic.—Domestic expenditure, which last year reached a total of £29,000, includes as its largest item £18,500 for fuel and lighting, of which £13,859 went in coal alone.

CHART 8.

DOMESTIC.

					£	s.	d.
1.	Renewal and Repair of Furniture ...				1,167	2	2
2.	" " " " Bedding and Linen				3,815	4	8
3.	Renewal and Repair of Hardware, Crockery, Brushes, etc. ...				1, 850	5	7
4.	Washing (see Returns).						
5.	Cleaning and Chandlery				1.855	19	10
6.	Water...				308	17	5
7.	Fuel and Lighting :—						
	(a) Coal	13,859	3	10			
	(b) Gas	1,467	5	9			
	(c) Electric Current	2,944	6	7			
	(c) Oil, Wood, etc.	215	14	5			
					18,536	10	7
8.	Uniforms (Nurses, Porters, etc). ...				1,681	11	9
9.	Sundries				479	14	0
					29,695	6	0

You will, of course, remember that our expenditure on coal at Guy's is very heavy, be-

cause we make our own electric light, and with the surplus steam from the boilers required for the dynamos we heat the Hospital. We produce electric light extremely cheaply, and we wash $1\frac{1}{4}$ million articles in the Laundry per year, at a cost of a little over 1d. per article.

If we did not make our own electric light, our bill for coal would be considerably smaller, but our bill for electric light would be considerably more than the saving in the coal.

The cost of Water only amounts to £308 per annum, but I am afraid that this is the last year for which we shall be let off as cheaply in this respect. By the new Metropolitan Water Act the cost of water next year will probably be between three and four times as much.

The Hospital uses on an average a million gallons of water a week, and 50 million gallons of water at $5\frac{1}{2}$d. a thousand gallons will be a very heavy charge on the Hospital.

Uniforms.—I think it may interest you to know in passing that all the Nurses' uniforms in the Hospital are made in our Sewing Room by a staff of 9 persons, and as the result we can give a Nurse her uniform at a cost far lower than that we should have to pay for it outside.

These in their main outlines are our chief items of expenditure.

The next question which I want to bring home to each individual member in this audience is, "How can I save money for the Hospital;"

Firstly, I would bring to your notice this one important fact:—

CHART 9.

HOSPITAL.	IN-PATIENTS.—Cost per occupied bed in respect of the undermentioned items.					
	Beds occupied	Provisions	Surgery and Dispensary	Domestic	Salaries and Wages	Management other than Official Salaries and Pensions	Total
		£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.
Charing Cross ...	216·68	55 13 1	11 13 5	51 6 4	54 11 8	0 19 8	174 4 2
Guy's	530·70	51 12 5	13 19 6	54 18 2	55 2 2	1 6 0	176 18 3
King's College ...	341·67	67 2 0	30 4 4	73 3 0	66 12 0	1 7 8	238 9 0
London	783·41	60 14 1	20 5 11	54 5 9	82 9 10	0 19 11	218 15 6
Middlesex	333·48	43 14 1	19 9 10	40 1 5	56 4 7	1 19 1	161 9 0
Royal Free	172·44	55 2 6	18 11 9	52 5 1	73 18 5	1 17 11	201 15 8
St. George's	313·08	61 3 4	22 1 7	60 3 2	55 0 8	0 18 0	199 6 9
St. Mary's	235·04	52 1 10	24 10 11	51 9 0	68 3 8	2 3 0	198 8 5
St. Thomas's... ...	440·34	66 4 10	27 5 0	70 10 6	76 6 6	1 19 0	242 5 10
University College ...	310·03	57 12 9	12 19 6	43 5 11	36 17 0	1 1 4	151 16 6
Westminster ..	190·48	64 16 3	17 16 6	44 3 6	51 9 8	1 4 3	179 9 9
Total Beds occupied and Group Averages	3,867·35	58 2 6	20 3 3	55 6 7	64 2 9	1 7 8	199 2 9

Of every £1 spent in Guy's Hospital 1s. 8d. *goes in Coal.* Every hot water tap left running; every radiator turned on unnecessarily; every unnecessary electric light left burning; every bath filled unnecessarily full of hot water wastes Coal.

Strict economy in the use of Hot Water, Steam, and Electric Light will reduce out Coal Bill and will be of direct benefit to the Hospital.

Let me, also from the point of view of Coal Economy, emphasise the fact, the electric lifts

throughout the Hospital use by far the greatest amount of electricity.

Everybody—Student, Nurse, or Wardmaid—who uses a lift to go up one floor, or even, as I often see, uses the lift to come down a floor or two instead of walking down, is wasting electricity, and therefore Coal, and is spending the Hospital's money by sheer laziness.

Saving the Hospital money is just as valuable as giving the Hospital money.

Strict economy in all these little ways will save the Hospital money which runs into thousands a year.

In other matters of expenditure you are no doubt aware that the House-Committee circulates monthly and quarterly returns in respect of Provisions, Drugs, Dressings, and all Household articles, in which Ward is compared with Ward and Department with Department.

I believe that these returns are read with very great interest by those who see them, and I think it is true that these monthly and quarterly returns have a very great effect in promoting economies throughout the Hospital generally.

I think many of you at Guy's think that the Hospital is a very stingy place in that authority has to be obtained for the purchase of the smallest article, or the spending of the most trivial sum of money. It is only by this "stinginess," by always bearing in mind that economy must be brought to bear in every expenditure, that we can keep anywhere within the limits of our income.

And what is the result of this struggle for economy in every department of the Hospital?

The list published in the Statistical Return of King Edward's Hospital Fund shows the cost per occupied bed for the 12 larger London Hospitals with Medical Schools. You will see that of the four larger London Hospitals, Guy's is the cheapest, and it is only beaten in the race for economy among them all by three of the smaller hospitals.

It is always our aim at Guy's that some day we may be the most economical of the lot and appear lowest in the list per occupied bed.

These in brief are some of the salient points in our Income and our Expenditure.

Each and all of you can help the Hospital in one of two ways:—

Firstly, by interesting your friends and the charitable public outside in the work of the Hospital, and appealing for support on its behalf by making a claim which I think can be thoroughly justified, that all money given to Guy's Hospital is spent in the most economical manner possible.

Secondly, even if you cannot assist the Hospital by bringing in money towards its funds, you can help it equally by doing your share in promoting economy in expenditure.

As I have said before, sixpence saved to the Hospital is equal to sixpence given to the Hospital, and I am only asking each one of you to-day to make it one of your aims, in so far as you personally are concerned, that you will do your best to husband the Hospital's resources.

Guy's Reunion Dinner.

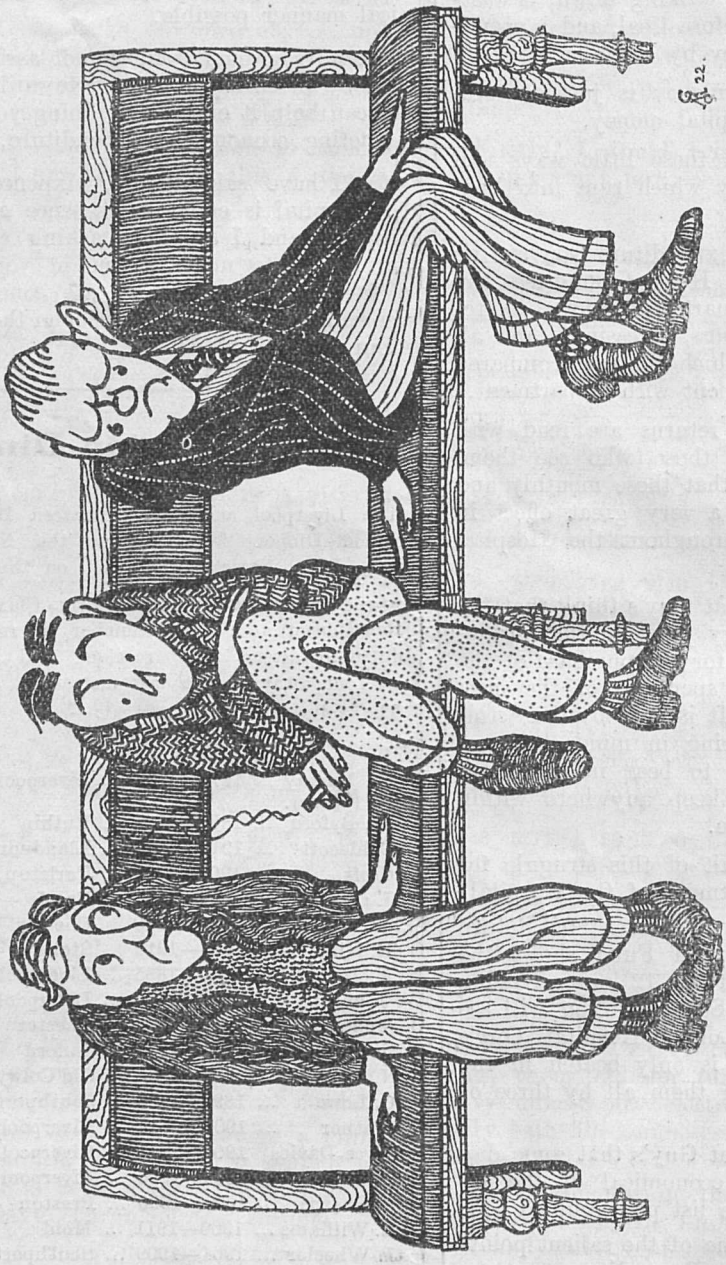
The Liverpool and North Western District Guy's Reunion Dinner, was held at the North-Western Hotel, Lime Street, Liverpool, on November 8th.

Music was contributed by Messrs. Claxton, Johnson and Caldecott. A large number of regrets at inability to attend were received and urgent cases kept four away at the last moment.

The following were present:—

	Years at Guy's.	
R. W. Murray (Chair).	1879—1884	Liverpool
W. F. Byford	1889—1895	Ruthin
F. Caldecott	1913—1917	Llandudno
L. Croft...	1902—1909	Tarleton, nr. Preston
E. J. Claxton	1898—1901	Bootle
W. H. Grace	1913—1918	Chester
G. R. Hind	1904—1912	Stoke
H. E. Jones	1880—1885	Liverpool
W. Johnson	1902—1920	Liverpool
C. Jephcott	1894—1896	Chester
S. Hodgson	1895—1903	Salford
A. N. Leeming...	1902—1910	Old Colwyu
E. C. Lowe	1899—1905	Southport & Liverpool
H. Mather	1906—1914	Liverpool
J. Pryce-Davies	1902—1911	Liverpool
W. Ramsden	1893—1896	Liverpool
F. A. Sharpe	1899—1905	Preston
O. E. Williams	1906—1911	Mold
F. J. Wheeler	1904—1909	Southport
F. H. Wood	1899—1906	Bootle.

H. MATHER,
Hon. Sec.



A study of three gentlemen lounging in comfort upon one of the beautiful new divans in the Externs' Room.

Reviews.

The Psychology of the Criminal. By M. Hamblin Smith, M.A., M.D. (Messrs. Methuen & Co., Ltd., London.) Price 6s.

The importance of the psychological investigation of the criminal, originally brought into prominence by the work of Dr. William Healy, of America, appears to be fully appreciated by the judicial authorities in Birmingham, who have given Dr. Hamblin Smith ample opportunity of pursuing this type of work. Great benefit has consequently accrued therefrom, both to delinquents and to society as a whole.

The work under review has been written on a strongly deterministic basis and with marked bias towards psycho-analysis.

The scope of the book is by no means so limited as its title suggests, the author obviously having a great knowledge of general psychology outside the confines of criminal responsibility. He is particularly to be congratulated on the concise manner in which he expounds the tenets of the Freudian School, thus rendering them intelligible to readers previously ignorant of this recent branch of psychology.

With reference to the specialised investigation of criminals, it is wisely urged that the modern legal attitude should be directed to elucidating why a man does wrong for "it is really as unreasonable to deal with an offender without due examination, as it is to prescribe for a patient without examination."

Many of the author's cases bear out his theories, several offenders having been saved by his interposition from that degrading imposition of our vaunted civilisation—imprisonment.

The *Osteograph* is a device to assist those Medical and Dental Students who are devoid of all artistic talent, to make diagrams of the skeleton. The outlines of the bones are cut out of celluloid and the tracing is simple. The outlines are rather crude in many cases, but some students may find them helpful. It is published and sold by Messrs. H. K. Lewis & Co., Ltd., of 136, Gower Street, the price being 6s. 6d. net.

The Golf Club.

In the final of the Staff Challenge Cup, played over 36 holes, L. W. Cann defeated D. B. Whitlock by 3 and 1.

The October Monthly Medal was won by D. G. Bown, with a score of 83 net.

Rugby Football Club.

At the annual General Meeting of the Rugby Football Club the following officers were elected:—

"A" XV.—Captain, H. G. Close; Vice-Captain, S. P. Jacobson.

Extra "A" XV.—Captain, S. P. Meacock; Vice-Captain, F. F. Brayfield.

"B" XV.—Captain. G. G. T. Tregarthen; Vice-Captain, H. Lewis-Phillips.

Nomads.—Captain, G. D. Shaw; Vice-Captain, R. R. Macintosh.

First Year Representative on the Committee.—H. Daneel.

After a lengthy discussion the following motion was passed:—

"*That in future the reserves be substituted for those members whose names are not ticked off on the respective lists by 2 p.m. on the day preceding the match.*"

S. P. MEACOCK,
Hon. Sec.

GUY'S v. LONDON WELSH.

Played Saturday, November 25th, 1922, at Honor Oak Park.

Its rather monotonous to constantly refer to our weakened side. A reference to the team will therefore suffice and it is good to know that all the damaged members of the First XV. are doing well. C. L. Steyn will be some time before his re-appearance, the remainder, one hopes, will resume after the Christmas interval.

The London Welsh had a good side out, the assistance of Marsden-Jones, an old International, was not available till the match had progressed some little distance. Other Internationals helping the Welshmen were Melbourne Thomas and Stephens. Our full back was J. G. Van Schalkwijk, and this sportsman played a magnificent game. His kicking was great; again and again with uncanny accuracy did he punt and find touch close by the corner flag. Albertijn played at stand-off half, and from this position he made some excellent attempts at goal dropping, one excellent effort opening the score. Now and again the Welshmen passed, but our tackling was better than some of recent date, and the last line referred to above was impenetrable. Of the forwards seldom has Scholefield played better, his example might have been followed by some of the others, who were slow in the open, Neser excepted. In the scrums we got the ball as many times as our opponents, and the threequarters, of whom Fellows-Smith showed great promise, passed fairly well. But they were not trusted often with the ball. The kick ahead or punt for touch being

favoured. With half-time approaching a weak tackle allowed Michael plenty of time to look around and pass leisurely, wide out to the left, Butler-Thomson scoring and Marques kicking a splendid goal. Michael should have been put down, and no half measures adopted.

Neser put on a penalty goal soon after recommencing. With this lead our men played better and Fellows-Smith broke through in good style, punted ahead and scored, Van Schalkwijk goaling. A little later Neser, taking full advantage of a slow clearance, dashed up and scored a try. Conversion followed and we were now 16 points to 5 to our opponents. We attacked from now to the end, but no further scoring was done by either side. Bekker was a tower of strength in his old position; though far from fit, his reappearance was very welcome, and his turning out plucky and sportsmanlike. Albertijn one scarcely likes to criticise, but is so magnificent a threequarter wise in playing at stand-off half? Of the forwards almost unnoticed was the sterling work of Holloway and Hutchinson, shoving like Hades. One fears too often the good un in the loose gets the plums, but the good un in the tight plays his heart out unnoticed.

Guy's Team.—J. G. Van Schalkwijk, L. Weinburg, G. R. Mostert, R. Fellows-Smith, A. Hirschberg, F. Bekker, P. K. Albertijn, E. E. Neser, B. G. Scholefield, F. H. Hutchinson, P. G. Harvey, N. M. Holloway, D. W. Percival, P. W. Schabort, N. L. Eckhoff.

GUY'S v. OXFORD UNIVERSITY.

Going down to Oxford on Wednesday, November 29th, and getting defeated by 2 goals and 1 try to nil was not a very serious trouncing considering the 'Varsity are nearly at the end of their winding-up stage prior to their game with Cambridge. Still, it is some years since we have been beaten by both Universities in the encounters that take place before the Universities meet. These are the matches that matter as neither Cambridge or Oxford field so strong a side after the Battle of the Blues is over. Watching the game one rather wondered how we had so much of the play, so often had we the ball, and so often had we the better position and yet so little did we do with it.

A few minutes after play commenced our defence was twisted up, David, received from Richardson and passing finally to Macintosh, that player gained a try so favourably placed that Lawton goaled with ease. The Hospital pack now got well down to the Oxford "25," but nothing came of it. Hereabouts Kittermaster chipped in and running well, he passed to German who gained Oxford's second try and Lawton again did the needful. Again our forwards rallied and Finnemore got away, but was collared. Fellow-Smith looked a scorer, but he kicked instead of going on. Oxford pressed towards the half-time interval, but nothing more was scored.

Going at it again after the lemon period, David threatened danger, but was fortunately kept out. Albertijn was keeping things very tight, constantly touch finding, and his threequarters had to find their own opportunities. Scarcely ever did they get going with a passing run, though one good bout, when Weinburg got away from the last pass, seemed to prove that they could be trusted much more often. The end was now approaching and we were well placed, surely it was not too late to save the game. If already beaten what matter'd another try or two against us, but giving the ball air, the threequarters a chance, and putting one's trust in the gods and not in the touch line, might surely have turned the tide. Anyhow for some reason, lack of thrust, too much finesse and perhaps too little "ginger," we did not cross the Oxford line and we had one more try against us.

Result:—Oxford University, 2 goals 1 try (13 points), Guy's nil.

Guy's Team.—J. G. Van Schalkwijk, A. Hirschberg, R. Fellows-Smith, H. Finnemore, L. Weinberg, F. Bekker, P. K. Albertijn, E. E. Neser, B. G. Scholefield, P. G. Harvey, N. M. Holloway, W. H. Taylor, R. W. Percival, F. G. Hutchinson, J. W. Schabort.

GUY'S v. SWANSEA.

There were many counter attractions in London on Saturday, December 2nd, the crowd at Honor Oak Park therefore was not quite so great as one would otherwise have expected Swansea to draw. They were not quite at full strength, T. Parker, their most notable forward was away. Very punctually the teams turned out and thus kept up the reputation which the Hospital ground has won for turning out to time. Guy's at once took up the attack and the forwards got the ball out several times to our threequarters who made such excellent use of their opportunities that Van Schalkwijk burst through and passed to Finnemore on the wing, who scored an unconverted try within five minutes of the commencement. This early promise put heart into the side, and Finnemore repeated his success, but the try was not allowed. Mr. T. H. Vile, of Newport, was the referee and no better wields the whistle to-day, but he was a little lenient with the visiting halves, E. Williams and D. J. Hughes. Remarkably smart were these two players, quick and virile in the extreme. They got their back division going several times and it must be said that when the visiting quartette got moving they always looked dangerous. However, our men were tackling much better than usual. Once or twice we were pressed to the line, but the defence held. In midfield Fellows-Smith

broke through twice in most promising style, but having beaten his man, his effort does not last. A high kick and follow up by Guy's looked hopeful, but Grey, the Swansea full back, made a wonderful mark close to his own goal and our forwards towards the half-time were tiring.

The second half they tired more, Neser was no longer in the pack but among the three's, and the already tiring seven had more thrust on them than they could be expected to stand. These men have bravely upheld the Guy's standard for three weeks in some very hard matches and twice have they put in two matches a week. All honour to them for doing as well as they did, and even so, we were unlucky to lose. Swansea got two tries this second portion. The first soon after ends were changed and the second five minutes before the end. This last, T. A. Shaw, our full back, punted into the face of a Swansea forward, who ran on and touched down. No blame attaches to Shaw, he was highly tried and he kept steady and calm under much pressure, and when he tackled his man went no further. It was a great game, the turf a little too treacherous to favour exact play. But it was the same for all. Taylor was good. Hutchinson and Scholefield untiring. It was pleasant to see Zondagh in the pack again. Finnemore has great pace and dash. Bekker had a great task but did it well. One would like to see more confidence placed in the threequarter line, they are worth it, they won't score every time they get the ball, but it will give them more opportunity if they are allowed more run for their money.

Result:—Swansea 2 tries (6 points), Guy's 1 try (3 points).

Guy's Team.—T. A. Shaw, H. K. Willams, R. Fellows-Smith, J. G. Van Schalkwijk, H. Finnemore, F. Bekker, P. K. Albertijn, W. H. Taylor, E. E. Neser, F. G. Hutchinson, P. G. Harvey, G. Zondagh, B. G. Scholefield, F. W. Schabort, N. M. Holloway.

Association.

GUY'S v. R.M.C. (SANDHURST).

At Honor Oak Park, on Saturday, December 2nd, we met Sandhurst who, earlier in the season, defeated the Hospital by 4—2.

Owing to the absence of Weyman, at outside left, Pickett made his first appearance in the eleven, and really played a splendid game, despite the fact that he was well marked by the Sandhurst skipper. The inside forwards were slow and many chances were missed from the accurate centres of both wing men.

The first goal came through Couch, who from a difficult angle sent in a "first time" shot, which completely beat the opposing keeper.

The play during the first half was very even, with little to pick between the two teams. During a scrummage in the Sandhurst goal the ball was thrown back into midfield by the goalkeeper; Pickett running up sent the ball into the net with a well-placed shot.

Couch again scored before the interval. During the second half Guy's monopolised the game, pressing hard the whole time. The opposing goalkeeper played a magnificent game, making some wonderful "saves." He undoubtedly saved Sandhurst from a heavy defeat. Their forwards were very fortunate in scoring on the only three occasions they broke away. Couch again scored before the final whistle blew.

Final score:—Guy's 4, Sandhurst 3.

Boxing.

GUY'S v. OXFORD UNIVERSITY.

This match took place on the evening of November 9th, not in the O.U. Boxing Club Gymnasium as in the two previous years, but in the Corn Exchange at Oxford, which had a larger ring and more accommodation for spectators. Guy's won the match by four fights to three. The Hospital won the first four fights straight off the reel, but then lost the last three all by knockouts.

The crowd, who enjoy blood and knockouts, had a good evening's "sport." The house was packed.

Bantams.—A. Lewis (Guy's) beat F. W. Harrold (Hertford) after a close and scrambling fight, which was the least interesting of the evening.

Feathers.—J. D. S. Thomas (Guy's) beat K. McColl (Non-Coll.) McColl was a Cambridge boxer, having won the Inter-Varsity feathers in 1920 and 1921, but has recently transferred his activities to the sister University. He is short and stocky in build and possesses a dangerous right. Thomas, much the taller of the two, was entirely unimpressed by his opponent's reputation, and immediately began to force the pace as is his habit. He skilfully avoided McColl's right, and won the best fight of the evening by his constant attacking. Seeing that he had been ill two days before, and was not in best condition, his was a most creditable performance.

Lights.—J. G. S. Thomas (Guy's) beat J. Q. Dealey (Hertford). Thomas is really more of an Oxford boxer than his opponent, having been Captain of the O.U. Boxing Club last year, and having won, in the course of his three years residence at Oxford, every single fight in which he competed for the University. He shares his brother's tirelessness and ceaseless aggressiveness. On this occasion he wore his man down, and the fight was stopped in the third round, when Dealey was more or less helpless.

Welters.—G. V. Lloyd-Williams (Guy's) beat P. I. Bell (Queen's). These two were old opponents, having met twice before on both of which occasions Lloyd-Williams lost. On this occasion, however, he very creditably retrieved himself. Bell is a quick and clever boxer, difficult to land on, and with a very fast left lead, but he boxes too much on the

retreat. From the first gong Lloyd-Williams was after him, and chased him round the ring for the three rounds, in the course of which he probably received more punches than he gave, but nevertheless won by forcing the pace throughout. Decisions in these sort of fights are difficult to give and judges vary much in the number of points they allot for aggressiveness as against punches landed. In this case Lloyd-Williams cannot have won by much.

Middles (First String).—J. A. Buchanan (Balliol) beat H. Trafford (Guy's). Buchanan an inexperienced, but strong and steady boxer, immediately began to force the pace. There was not much in the first round. In the last moments of the second round Trafford shipped some heavy punches, and was finally floored by a left to the solar plexus, six seconds before the end of the round, so that the gong signalling the end of the round sounded with Trafford on the canvas. He was helped to his corner by Hewitt, was nursed round, and came up gamely for the last round, receiving deserved applause for doing so. Buchanan immediately attacked him furiously and finished the fight by a left swing to the jaw.

Middles (Second String).—Magnis Clydesdale (Balliol) beat G. Fellows-Smith (Guy's). There was not much in the first two rounds. Clydesdale, an ungainly boxer, who is dangerous when mixing, was perhaps more aggressive at the end of the second round, in neither of which there was much science displayed. In the last round Fellows-Smith caught a left hook on the jaw in the Oxford corner, and went down. Dick Smith, the Oxford trainer, tipped him when to get up, which he did, arousing loud applause. He staggered to the middle of the ring, where he suddenly fell down unconscious without Clydesdale hitting him again.

Light Heavies.—E. P. Eagan (New College) beat N. M. Holloway (Guy's). Eagan was the draw of the evening, having come over this autumn from America (where he had boxed all the big American heavyweights including Dempsey), with an enormous reputation. He had also created a sensation by challenging Siki on the occasion of the latter's victory over Carpentier. As soon as they shook hands, Holloway attacked his formidable opponent, and surprised him by hitting him very hard on the cheek. They then mixed, and Holloway caught a short left clip on the jaw, falling flat on his face, and removing half-an-inch of skin from his nose on the canvas. He got up and continued fighting, but shortly afterwards received a smashing right on the jaw, and the fight was stopped.

C. P. BLACKER.

Swimming Club.

The Annual Dinner of the Club was held at Maxim's, Wardour Street, on Friday 10th November. In the unavoidable absence of the President, Sir Alfred Fripp, the Dean of the Medical School took the chair, supported by Dr. Allport, Mr. Ormond, Mr. Layton and Mr. Philip Turner. Letters of regret for their absence were read from Sir Alfred Fripp, Dr. Eyre, Mr. Thomson, Mr. Rowlands, Mr. Hughes and Mr. Steward. There were some 35 members present. After "The King," had been drunk, Dr. Allport proposed the "Hospital Medical School"; the Dean replied. Mr. Meacock proposed the "Club," and wished it yet another "shuckesshful sheashon"; the Secretary replied. Mr. Wakeford proposed the "President and Vice-Presidents"; Mr. Layton replied. Mr. Ormond proposed the "Ladies"; Mr. L. S. Williams replied.

Messrs. F. G. Hutchinson, J. D. S. Thomas, T. McD. Kellough and J. E. Piercy rendered a well-known song in a manner which was truly pathetic and brought tears of sympathy to the assembled company. Mr. Ensor accompanied at the "pianos." Mr. Philip Turner proposed a vote of thanks to the vocalists, and hoped they would "do it again"—somewhere else! The Secretary proposed the toast of "Scotland" and after singing "Auld Lang Syne" the company broke up at 11 p.m. Some went home immediately—some didn't! One hears rumours of breakfasts at 3 a.m. in Gerrard Street, and 6 a.m. trains at Charing Cross; people do talk so!

Appointments.

Kenneth Black, F.R.C.S., appointed Professor in Surgery at King Edward VII. College of Medicine at Singapore.

W. H. Ogilvie, M.S., F.R.C.S., Surgeon to Out-Patients at the Hampstead General Hospital.

G. W. Elkington to be Medical Registrar at the Bristol Royal Infirmary.

Publications Received.

British Medical Journal, Isis, Old Cambridge, New Cambridge, Dragon (Aberystwyth), Nursing Times, The Antiseptic (India), The Prescriber, The Queen's Medical Magazine (Birmingham), King's College Hospital Gazette, London Hospital Gazette, The Hospital Gazette, The Hospital and Health Review, Abstracts of Bacteriology, Raw Materials Review, New York State Journal of Medicine, B.M.A. Annual Handbook, St. Thomas's Hospital Gazette, The Serpent (Manchester), St. Mary's Hospital Gazette, St. George's Hospital Gazette, Indian Medical Record, The Sphinx (Liverpool), The Medical Journal of South Africa, Architectural Association Journal, Charing Cross Hospital Gazette, College of Nursing Bulletin, Bratislava Medical Journal, Magazine of the London (R.F.H), School of Medicine for Women, St. Bartholomew's Hospital Journal.

Deaths.

RYLE.—On the 4th December, at Guy's Hospital, Reginald John Ryle, M.A, M.D., J.P., of Pangbourne, Berks. (formerly of Brighton), eldest son of the late J. C. Ryle, Bishop of Liverpool, aged 67 years.

VILJOEN.—At Bredasdorp, South Africa, at the age of 3¼ years, Niel, the only son and child of Mr. and Mrs. W. J. Rousseau Viljoen, L.D.S., R.C.S.Eng. Deeply mourned.

ED.—J. A. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THIS is the last number of the 1922 volume of the GAZETTE, and, as before our reappearance both Christmas and New Year's Day will have passed, we take this opportunity of wishing all our readers a very happy Christmas and a prosperous New Year. Even though the January examinations loom ahead; endangering our individual peace of mind amid the general rejoicings, it is well for a time to cast aside all carking care and to devote ourselves to the pleasures of Christmas.

For the moment examiner and examinee, like Isaiah's wolf and lamb, may dwell in peace together. (Strictly speaking, we do not believe that examiners come up to the standard of peacefulness reached by the prophet's wild beasts. They are probably hatching out some dastardly plot all the time, though outwardly unruffled and kind-looking. But we do not trust them. At best, our peace can be but an armistice.)

Christmas at the Hospital almost rivals Christmas at home, in the jollity and good feeling which pervade the very air. Those who have not yet spent at least some part of the Christmas week at Guy's, in previous years, have missed a great deal.

The general relaxation of the more business-like relations of everyday life, so that work is performed as expeditiously as possible in order to leave time for festive preparations; the bustle of these preparations, with the countless weighty problems involved; days spent by the more industrious in the production of works of art designed for ward decorations; the later efforts of their less talented brethren, who are content merely to accept employment as holly-hangers; pianos in the wards; permission to smoke during Christmas week; the interest of the older patients, and the excited anticipation of the children;—all these combine in making Christmas an unforgettable season at Guy's. We say nothing of the results of these efforts—the wards resplendent in their unwonted attire, the Niggers, the Ward Concerts, and the Christmas Trees, and other entertainments for children. Even if our modern Scrooges are not likely to be converted from their uncompromising harshness by the voices of carol singers, Christmas at Guy's is certainly an efficient antidote to the system which "makes Jack a dull boy."

We advise everyone to make a point of being here for at least some part of the week.

THE Landon Out-Patients' Tea Fund is still in need of subscriptions. Most of us have already been met by the gentleman with the receipt book. Is it too much to ask those who have not, to go out of their way to meet him?

WE have much pleasure in announcing that H.M. the King has set an example to Christmas givers, by sending a donation of £10 to the Guy's Hospital Christmas Fund.

We are very glad indeed to see Dr. Hunt back at the Hospital, again at work. Everyone at Guy's will join with us in welcoming him back, and in wishing him the best of health and happiness in the New Year.

Subscribers are reminded that the annual subscription of 12s. 6d. for the Gazette and Directory is now due. Subscriptions should be sent to Mr. W. J. Curry, at the Gazette Office. In the 1923 edition of the Directory many mistakes and omissions have been rectified. It is hoped, not altogether without reason, that sufficient support will be forthcoming to make the revision of the Directory an annual affair. We have recently received the subscriptions of over seventy new subscribers.

The acquisitive instinct is strongly implanted in the human breast, and one of its most distressing manifestations is the moral subversion to which it subjects some of those who are wont to make use of books. We all know the friend who borrows a book and fails to return it. Sometimes we even hear of gentlemen who possess magnificent libraries which are gradually built up by the same nefarious method of acquisition. The book-collector is almost as bad as the umbrella-collector. Dead to all the higher emotions, he can only be checked in his criminal career by stern measures. We are loath to believe that the depletion of the Library (which is announced on page 512) is due to the existence within the Hospital of such graceless persons. Even if the losses are attributable to the mere carelessness of borrowers, however, their neglect should be visited with suitable punishment. Some Mikado-like librarian, gifted with that potentate's powers over his subjects, might condemn the delinquents to appear before a High Court and give satisfactory evidence that they had made good use of the borrowed books, even submitting them to a prolonged examination, both oral and written, at the same time demanding the return of the volumes in question (refusal to do so meaning even worse tortures).

But we fear that such a consummation, however devoutly to be desired, is impracticable in the age in which we live.

All we can do is to appeal to the borrowers, asking them to make haste, like good fellows, and return those books.

We announce, with deep regret, the recent deaths of two old Guy's men.

Dr. John Cheesman, who died on December 7th, 1922, at his residence in Castle Street, Buckingham, would have been 86 on the eighteenth of this month. An old friend, one of his executors, writes that Dr. Cheesman after his retirement always continued to take the deepest interest in Guy's and Hospital affairs, reading the Gazette regularly and enjoying, to the utmost, meetings with old Guy's men.

Dr. H. Lucas, of Huntingdon, who qualified in 1865, died on December 10th, 1922.

We hope to obtain details for obituary notices before our next issue.

We publish in this issue a photograph and obituary notice of Dr. R. J. Ryle, whose death was announced a fortnight ago.

At the moment of going to press we hear of yet another addition to the list of Guy's men whose death it is our sad task to record. Dr. H. Poole Berry, of Grantham, who qualified in 1882, was Resident Obstetrician and House Physician at Guy's. He has been closely identified with all that concerns the health of his fellow-citizens for many years, performing, in addition to his ordinary work as a practitioner, the duties of M.O.H., School Medical Officer to the Grantham Education Committee and Surgeon to the Grantham Hospital. A Major in the R.A.M.C.(T.), he served in the late war and held the Territorial Decoration.

His patients lose in him a kind friend and skilful adviser. To his family we offer our sincere sympathy in their bereavement. His

widow is the sister of a Guy's man, and his daughter was also associated with Guy's, having qualified here as a masseuse.

We direct our readers' attention to the notice which appears on page 519, announcing the Dinner which is to be held in aid of the Royal Medical Benevolent Fund Guild. It is hardly necessary to emphasise here the value of the Guild's work. The Royal Medical Benevolent Fund Guild has been forced, at the present time, to undertake the task of educating an unusually large number of children. In accepting this responsibility it was guided by two main considerations. Unskilled labour notoriously gives but a precarious livelihood, and while a good education will in time render these children independent and, it may be, a support to others, its absence will inevitably tend to make many of them a permanent charge upon the Guild. Still more it was felt that these orphans ought to be regarded as the children of the Profession and that it would not be right to allow them to fall, through no fault of their own, from the position which their fathers held.

This is the first time that a united effort, supported by ladies connected with all the great hospitals of London, has been made.

The War Memorial Fund is still in need of a further sum of £150, before all deficits are met, owing to the fact that the expenditure involved in the erection of the Memorial Arch exceeded the calculated amount by £150. We publish on page 518 an appeal for further contributions. It is to be hoped that the £150 will soon be forthcoming and that our War Memorial will be free from debt.

Contributions should be sent to Dr. Pembrey.

We remind unqualified men in the wards that students who intend to submit Essays on "The Diagnosis and Treatment of Jaundice arising from Obstruction of the Larger Bile Ducts," in competition for the Prizes offered by the British Medical Association, should give in their names at the Medical School Office at once. Essays should be completed and sent in by January 31st, 1923. For the conditions of the competition, intending entrants are referred to the notice on page 512, and to the notice outside the Medical School Office.

It would be a great pity if Guy's did not produce at least two or three entrants, and those who have the time to write an essay will certainly find that they have not lost by their industry, even if they do not gain the prize.

We also draw the attention of Senior Students to the fact that Essays on "The Blood Changes in Tuberculosis," for the Treasurer's Prize, should be submitted by February 28th, 1923. Conditions as to entry may be obtained from the Clubs' Union Year Book.

Not long ago we were the recipients of a present. It was a small blue book, entitled "How to Write Clearly: Rules and Exercises on English Composition." This outburst of generosity was apparently occasioned by an article published not long ago in the Gazette. Our correspondent, who styles himself "Marius" —is it in emulation of the heroically proper young man in "Les Misérables," or does our friend delve further into history than into fiction?—avers that he loves his language, and hates to see it mutilated, or even roughly handled.

We share his distaste for this cavalier treatment of the English language, but we cannot force all our contributors to adopt that incomparable grace of diction which characterises the paragraphs in this little book.

We should very much like to meet "Marius" and to have a conversation with him (or is it her?), as purist to purist. But, alas, he has obscured his identity with the veil of anonymity, and, unless we know his name we cannot continue the discussion.

Prizes offered by the British Medical Association for Essays by Students.

The Council of the British Medical Association will, in March, 1923, award Prizes of £10 each, for the best Essays on "the Diagnosis and Treatment of Jaundice arising from Obstruction of the Larger Bile Ducts," by final-year Medical Students, *viz.*: one Prize in each of the following Groups of Medical Schools:—

Group 1.—Aberdeen, University of; University of St. Andrews (University College, Dundee).

Group 2.—Belfast, Queen's University of; University of Dublin (Trinity College); National University of Ireland (University College, Cork; University College, Dublin; University College, Galway); Royal College of Surgeons in Ireland (Schools of Surgery).

Group 3.—Birmingham, University of; University of Bristol; University of Wales.

Group 4.—Durham, University of; University of Leeds; University of Sheffield.

Group 5.—Edinburgh, University of; School of Medicine of the Royal Colleges.

Group 6.—Glasgow, University of; Anderson College of Medicine; Queen Margaret College School of Medicine for Women; St. Mungo's College.

Group 7.—Liverpool, University of; Liverpool School of Tropical Medicine; Victoria University of Manchester.

Group 8.—London: Charing Cross Hospital Medical School; King's College Hospital Medical School.

Group 9.—London: Guy's Hospital Medical School; London Hospital Medical School.

Group 10.—London: London (Royal Free Hospital) School of Medicine for Women; University College Hospital Medical School.

Group 11.—London: Middlesex Hospital Medical School; St. Mary's Hospital Medical School.

Group 12.—London: St. Bartholomew's Hospital Medical School; St. George's Hospital Medical School.

Group 13.—London: St. Thomas's Hospital Medical School; Westminster Hospital Medical School.

2. The Prizes will be awarded to the Authors of the Essays deemed by the Examiners to be the best sent in from the respective Groups, but if no Essay received from a Group is deemed by the Examiners to be deserving of a Prize, no Prize will be awarded in respect of that Group.

3. The Essays, which should be clinical in nature, must include concise notes of not less than three cases personally observed by the student and illustrative of points in the Essay, and must not exceed 5,000 words.

4. Essays should be plainly written or typed on foolscap paper (one side only), and must reach the Medical Secretary, British Medical Association, 429, Strand, London, W.C. 2, *not later than January 31st*, 1923. Each Essay must be signed by a pseudonym, and be accompanied by a sealed envelope marked on the outside with the pseudonym, and containing inside a signed and dated statement that the Essay has been the *bona-fide* work of the competitor, and that he or she has not yet passed the final professional examination; together with particulars of his or her, name address and Medical School.

5. The Essays received will be adjudicated on by Examiners appointed by the Association from among Members of the Association *not* resident in the area of the particular Group, and the decision of such Examiners shall be final.

ALFRED COX,
Medical Secretary.

Books Missing from the Wills Library.

The following books, having been taken from the Wills Library, have been kept for a considerable time by those who borrowed them. Much inconvenience is caused by the absence of these volumes from the Library. Borrowers are requested to return at the earliest opportunity books which they have taken:—

Fagge. Pocket Anatomy.
Rawlings. Surface Anatomy.
Hutchinson and Rainy. Clinical Methods.
Ten Teachers. Diseases of Women.
Schaefer's Histology.
Rose and Carless. Surgery.
Johnston's Midwifery.
Bowlby and Andrews. Surgical Pathology.
Johnston's Regional Anatomy. 2 copies.
Woodwark's Medicine.
Waring's Operative Surgery.

Change of Address.

Dr. F. E. Shipway, 55, York Terrace, Regents Park, N.W. ('Phone, Langham 2331.)

H. J. Spon, "Linton," Littlestone, Kent.

Appointment.

O. Gayer Morgan, M.Ch., F.R.C.S., Hon. Surgeon Royal Westminster Ophthalmic Hospital.

Splenectomy.

CLINICAL LECTURE BY R. P. ROWLANDS, M.S., F.R.C.S.

GENTLEMEN,—I have performed splenectomy on two cases at present in the medical ward under Dr. Hurst; one of them is a middle-aged woman suffering from pernicious anæmia, and the other a young man with splenic anæmia. The contrast between these two operations, which were performed on the same day, was very great. In the woman—a very late case—where it was undertaken almost as a forlorn hope, the operation was extremely easy, the spleen being taken out within five minutes and the patient standing the operation well. She has since felt much better and there is already great improvement in the condition of the blood although the operation was only done five weeks ago. In the case of the man, who had suffered from repeated, grave hæmorrhages for several years, the operation, which lasted about an hour, was difficult owing to extensive adhesions between the very large spleen and the parietes. He has not done so well, having had an abscess in his flank and clotting of the right axillary vein, but he is gradually getting better.

It has been known for a very long time that the spleen is not essential to life. It is sometimes absent in animals and also in men without apparent detriment. Sir Berkeley Moynihan,[1] in his Bradshaw Lecture on the Surgery of the Spleen, goes into this question very thoroughly.

CONSEQUENCES OF LOSING THE SPLEEN.

There is a temporary increase of white blood corpuscles, especially of lymphocytes, for about a year, and the eosinophile cells to 8 per cent. for about three years. There is a temporary decrease, for about two months, of the red corpuscles which become more resistant to hæmolytics. There is over-action of the lymph glands and bone marrow in blood-making; the glands may become enlarged and the bones tender. Splenectomy makes infection a little more likely and is apparently followed by some loss of fertility.

A few remarks upon the history of Splenectomy, taken from Sir Berkeley Moynihan's lecture may be interesting.

Zaccarello, an amateur surgeon, successfully removed the spleen in 1549, and Fioravanti, who helped him, describes the operation:—

"I went to see the lady and made preparations with her and with her husband, and having done so, went to the Justices, to give her up for dead, as is usually done. And, having permission, we went one morning to the lady's house. The good old man took a razor and cut the flesh above the spleen, which being cut, came out of the body. We went on separating it from the reticulum, and took it all out, and sewed up the flesh, leaving only a small opening. I dressed it with mixed oil of hypericum, incense powder, mastic, myrrh and sarcocolla, and ordered her a drink of boiled water with ordinary honey, comfrey, betony and holy-thistle, and every day I made her take a dose of theriac."

In the 17th century, Matthias, a surgeon of Colberg, removed a spleen which had prolapsed through a wound, and we have the following account:—

"In the morning, at the request of the magistrate, Nicolaus Matthias, a surgeon of Colberg, arrived and found the unhappy man immersed in blood and the swollen spleen protruding from his body. All who were present, with the priest, saw the spleen and were astonished at seeing so large a viscus protruding from the wound. By the aid of milk and herbs of a nature suitable for fermentation, the surgeon proceeded to tend the wound, and about sundown had the patient transferred to Colberg. On the following day a physician was called into consultation, and the surgeon showed him the swollen and protruding spleen, and enquired of him whether he should excise it. The physician, who said the authorities had taught that no one could live without the spleen, was averse to this being done; the blood flowing from the organs within the abdomen in large amounts would be without a proper passage for or method of exit. The surgeon, on the contrary, because the spleen was protruding considerably through the wound, said that he could not see that it was possible to replace the spleen in its proper position in the body, and that he considered it would be better that it should be removed. The patient consented to this; he turned in this critical moment of impending death, and said that he was prepared to suffer everything patiently.

The surgeon then ligatured the protruding portion of the spleen with a silk cord and withdrew the entire viscus from the cavity of the body. Next, that portion where it was adherent to the body he constricted with a cord, and on the third day afterwards he resected the whole spleen, and checked the abundant hæmorrhage with styptic powder. By the employment of suitable medicaments he restored the patient to health within the space of three weeks, although there remained in the wound a small swelling resembling a hazel nut, because at that place the vessels were adherent to the divided tissues. To this day the man lives happily with his wife, not deprived of off-spring, and carries on his ordinary occupation."

Clarke, of Somerset, also successfully removed a spleen prolapsing out of a wound, about 1676, and he performed the first experimental splenectomy on a dog. The animal recovered.

In 1669 Malpighi ligatured the splenic artery in a dog. This operation resulted in almost complete atrophy of the gland.

The first splenectomy deliberately performed in England (the fifth in the history of the operation) for an enlargement of the organ, is related by Spencer Wells in 1866. The patient was a married woman of 34 years of age, who "was evidently dying from a large spleen," and who had no other disease. She died of septicæmia about six days after the operation.

Thomas Bryant performed the operation twice for leukæmia at Guy's, in 1866 and 1867. Both patients died from hæmorrhage, and Bryant comments as follows :—

"We have learnt two things from the cases related. Firstly, that enlargement of the spleen in leucocythæmia appears to be only a part of a general disease affecting the glandular system as a whole; and, secondly, that in splenotomy for such a disease there is a predisposition to hæmorrhage with which surgery is incompetent to deal. It can neither be foreseen by any amount of care, nor coped with by any amount of skill. Under these circumstances there is no shirking the conclusion that the operation is physiologically unsound and surgically unsafe, and, for leucocythæmia should not be performed."

Indications for Splenectomy at the Present Time.

1. *Rupture.*—The spleen may be ruptured from injuries, with or without wounds, and the resulting hæmorrhage is frequently swiftly fatal. In some cases, suture of the spleen or packing the wound with gauze has arrested the bleeding and saved life, but the best course is to remove the spleen at once.

Directly the abdomen is opened, the hand is passed through the enormous amount of blood, which is often present, to seek and hold the pedicle, which is then clamped and ligatured.

The spleen may also rupture and need removal in malaria and enteric fever. It sometimes ruptures very easily and after slight injury in these and other conditions. Mr. Girling Ball related a case of a young woman admitted into St. Bartholomew's Hospital with a ruptured spleen for which no explanation could be found except that she had been taken for a walk by a soldier who had put his arm round her and squeezed her.

2. *Wandering Spleen with twisted pedicle.*—A movable spleen may be a cause of pain and disability when the pedicle becomes twisted, and an operation—either splenopexy or splenectomy—has to be performed. The latter is generally chosen and, as a rule, proves easy and successful in these cases.

3. *Cysts—hydatid, blood, serous, lymphatic, and dermoid.*—As a rule splenectomy is indicated for these conditions, but it may be a difficult operation owing to adhesions. Sometimes a slight injury may induce bleeding into a splenic cyst. A spleen of this kind was shown at the Medical Society, a few days ago, by Mr. Gwynne Williams. A young man had been hit in the epigastrium by a football, and subsequently developed symptoms of left sub-diaphragmatic abscess, for which the operation was undertaken. The real condition was discovered at the operation, which was successful.

4. *Splenic anæmia, including von Jaksch's (Infantile) Disease.*—Splenectomy is the only satisfactory treatment for splenic anæmia, and it should be done early before perisplenitis develops with resulting adhesions, which add greatly to the risk of delayed operations. It should also be carried out before severe secondary changes (cirrhosis) take place in the liver

and ascites developes. In these later stages splenic anæmia is commonly called "Banti's disease."

Out of 71 splenectomies performed at the Mayo Clinic[2] there was a mortality of 12·6 per cent.

As I have said, the operation in the later cases may be extremely difficult owing to extensive adhesions and also to the size of the spleen. On this account it has even, in some cases, had to be abandoned.

There seems to be an especial liability to infection in cases of splenic anæmia and also to thrombosis in the splenic vein spreading to the superior mesenteric or portal vein, sometimes causing death from gangrene of the intestine.

It is interesting to note that after operation the liability to severe hæmorrhage, especially hæmatemesis, which is characteristic of splenic anæmia, is not entirely eradicated, for the bleeding may recur and even terminate fatally as many as seven years later. This happened in a case of a young man, whose spleen I removed in 1915—a patient of Dr. Hurst, and of the late Sir William Osler. He was in excellent health and his blood in good condition until sudden hæmorrhages occurred, apparently into his brain and stomach, and he died.

5. *Hæmolytic jaundice.*—This is a condition of anæmia with slight jaundice of the acholuric type—that is, there is no bile pigment in the urine and the fæces are not pale, but there is marked fragility of the red blood corpuscles. There are at least two varieties—the acquired and the familial—in which several members of the family may be affected.

The acquired form is by far the more serious and, without operation, is practically always fatal. In this condition splenectomy is most successful, being easy and attended with a low mortality. The Mayo Clinic publishes a record of 32 operations with a mortality of 3·1 per cent. There have been several very successful cases at this Hospital. The jaundice clears up in a few days, but the fragility of the blood corpuscles may remain for many years. Lord Dawson recently reported a case where the fragility persisted for thirty years after a successful splenectomy by Spencer Wells. It is interesting that, in more than half of these cases, biliary colic and gall-stones are present, and, in some, an operation for the removal of gall-stones had naturally not cured the jaundice. Either at the time of the splenectomy or subsequently the gall-stones have to be removed and the gall-bladder drained.

Operation is not so often indicated for the familial type of this disease.

6. *Egyptian, or Tropical Splenomegaly.*—Splenectomy has been very successful in the early stages of this condition and Owen Richards has published some interesting cases.

7. *Syphilitic Splenomegaly.*—In congenital syphilis splenic enlargement sometimes fails to react to medical treatment, and under these conditions splenectomy has proved very satisfactory.

8. *Tubercle of the Spleen.*—Occasionally tuberculosis may be limited to the spleen and splenectomy indicated. It proved successful in all of four cases operated on at the Mayo Clinic.

9. *Pernicious Anæmia.*—It is still uncertain whether splenectomy is worth while in Addison's or pernicious anæmia. It has been performed more on the Continent and in America than in England and was first suggested by Eppinger. At the Mayo Clinic there was a mortality of 5·6 per cent. in 53 cases. Giffin and Szlapka[3] recently investigated fifty splenectomised patients and "the pessimism which existed in the Clinic has been partly dispelled at least. It was found that 21·3 per cent. of the patients with pernicious anæmia survived the operation three years or more, living two and one-half times as long as the average in a similar group of non-splenectomised patients at the same stage of the disease, and that 10·6 per cent. are alive after more than five years. This clearly indicates in at least one-third of the cases that the average life of patients with pernicious anæmia is greatly prolonged and in about 10 per cent. the prolongation is sufficient to lead to the hope that cures may result in some cases."

Before splenectomy is considered, every endeavour is made to improve the condition of the patient, and the quality of his blood by the removal of all sources of sepsis, oral, appendical and sometimes biliary, the free administration of hydrochloric acid (for all these patients have achlorhydria) and step-ladder transfusion of blood.

Splenectomy has been performed for lymphadenoma (Hodgkin's disease), lymph-sarcoma

and leukæmia, but there is no proof that the operation has done any permanent good in these conditions. At the Mayo Clinic 26 splenectomies for leukæmia showed a mortality of 3·8 per cent. The operations were not undertaken until the enlargement of the spleen had been greatly reduced by X-ray therapy.

10. *Gaucher's Disease (Endothelioma of the Spleen).* — Splenectomy is the only hopeful treatment for this rare condition.

Other indications for splenectomy are septic spleen, abscess of the spleen, and aneurysm of the splenic artery.

A few words may be said upon the important question of the technique of the operation.

For splenic anæmia I prefer a long incision, extending from the epigastrium downwards to the left, one inch below the costal margin, for this gives more direct access to the spleen and its adhesions to the diaphragm. For this reason Vauverts also removes portions of the 8th, 9th, and 10th rib cartilages.

For other conditions, without adhesions, a left, long, high para-median incision is the best, for it gives better access to the pedicle and, in some cases, it allows necessary treatment of the biliary apparatus and appendix. The spleen is rapidly separated from the diaphragm, care being taken not to injure the latter, and its vascular communications with the stomach tied, care being again needed here to avoid opening the stomach. The spleen is then turned turtle forwards, the tail of the pancreas separated and the pedicle grasped after Balfour's method[4] "in such a manner as to compress the artery between the thumb and the finger and is held during a few heart-beats in order to allow the venous blood to drain from the spleen back into the general circulation. Two forceps are then placed on the proximal side, and one next the spleen, and the pedicle is divided. A cat-gut tie is made in the groove of the deeper forceps as they are removed, and a second tie in the groove of the second forceps as they are removed."

REFERENCES.

1. Moynihan, Sir Berkeley: The Surgery of the Spleen, Brit. Jour. Surg., 1921, viii., 307.
2. Collected Papers of the Mayo Clinic: 1920, xii., 528.
3. Collected Papers of the Mayo Clinic: 1921, xiii., 619.
4. Collected Papers of the Mayo Clinic: 1921, xiii., 631.

Obituary.

Reginald John Ryle, M.D.Oxon,, J.P.
1855—1922.

Reginald John Ryle ended his days within the walls of Guy's Hospital. He would not have wished it otherwise, for he was as loyal and devoted to his Alma Mater as she was conscious and proud of his worth and learning.

He was born sixty-seven years ago, the eldest son of Dr. J. C. Ryle, the late Bishop of Liverpool. His younger brother is the Dean of Westminster, formerly Bishop of Winchester.

Ryle came to Guy's towards the end of the 1870's from Trinity College Oxford, where he had taken a Second Class in Natural Science, having previously been at school at Repton. The "entry," as it is called, in the October in which he came up was the biggest of pre-war years. In those days the proportion of men coming from the older Universities was much smaller than is usual now—there would only be three or four in Ryle's position. His four years seniority to the average college or London University student, combined with his mental attainments and character gave him at once a prominent position as a leader of the students. But he was a very quiet leader, a sort of consultant leader, a philosopher to whom the men of action referred their doubts and difficulties—they took his advice because it was always wise.

Less than half the men got full dresserships in those days. Ryle was of course one of these and soon he was a clinical and then one of the two House-Surgeons, who at that time shared the responsibility of all the surgeons' and assistant surgeons' beds. Although his ward work was always of the best, Ryle found time for other interests. He was a keen member and President of the Physical Society, a very lucid and convincing speaker. There was no Debating Society at Guy's in those days, to the advantage perhaps of the Physical Society. Ryle, however, took an active part in forming and supporting The United Debating Society which met at Ridley's Hotel in Holborn and *united* both St. Bartholomew's to Guy's and also the medical to other professions and callings. C. B. Lockwood of Bart.'s, "Tommy" Lough, a city merchant and afterwards a prominent House of Commons man, Tom Stevens a solicitor, and Maurice Pocock an artist-architect, and others, still alive, were among the leading debaters. Some of these, especially Lough and Pocock aroused the meeting with their fiery eloquence, but none had more influence on the votes than Ryle with his well arranged facts and his cool logic.

As Ryle came near to the end of his student course at Guy's, his fellow students began to discuss amongst themselves his future prospects, especially the question of whether he would be chosen for the Staff. The opinion was commonly expressed that he was "too good for general practice," though it is doubtful if his fellow senior students who held this view knew much more about the opportunities of service in general practice than, unfortunately, do the senior students of to-day.

Five years' exclusive association with the consulting ranks of the profession gave medical students then, as now, an exaggerated view of the importance of this side of professional work. Had he desired it Ryle could doubtless have joined the Staff, since three men of his year, each of whom would almost certainly have freely admitted the inferiority of his claims to those of Ryle, obtained positions as demonstrators or registrars; but very shortly after his resident appointment Ryle married and started in general practice, which he continued to carry on, to the great advantage of his patients, in Bloomsbury, Barnet and Brighton until his retirement a few years ago. He was a busy practitioner, but fortunately not too busy to be able to give freely of his time to public work, both in connection with local administration and professional organisation. He was a convinced temperance reformer and gave much assistance by speaking for the cause. He was essentially a student and throughout his life kept up his enthusiasm, not only for the study of medicine, but as a practical astronomer, and a wide reader of philosophic and scientific literature. He studied Italian philosophy in the original texts, having taught himself to read the language after the age of 50. To the Medical Press he contributed articles on the Treatment of Tympanities by Abdominal Puncture; The Natural History of Rötheln; Infections of the Antrum in Influenza; and the Origin of Feeble-mindedness.

To whatever extent these wide interests may have interfered with the exclusive attention to business, which is often said to be essential to success in Medicine as estimated by income-tax payments and death duties and, in whatever degree a true though ever gentle candour may have been a handicap in success thus measured, these characteristics added greatly to Ryle's attractiveness and value as a companion to his many friends, and especially to his children.

On his retirement from general practice he went to live at Bradfield and was persuaded to accept the post of Medical Officer to the School. This gave him time to devote himself to literary work. He took up the congenial task of translating from Latin some of the hitherto untranslated works of Roger Bacon. With the help of an engineer son he fitted himself up an astronomical observatory and he watched with interest the plans which an architect daughter was preparing for a house at Pangbourne, which he recognised he could not hope long himself to occupy. The years of his retirement, despite periods of ill-health, were full of interest and useful activity and peaceful happiness.

Ryle married Miss Catherine Scott, a sister of Bernard Scott, who entered Guy's in the same year that he did, and of Alfred Scott, a few years his senior at the Hospital. Mrs. Ryle and four sons and four daughters survive him, his eldest son being Dr. John Ryle, Assistant Physician to Guy's and Warden of the College.

British Empire Exhibition, 1924.

The British Empire Exhibition, to be held at Wembley in 1924, promises to be one of the most important and interesting events of the year, as the arrangements now in progress for its completion, are being prepared on a scale so immense, as to dwarf anything of the kind hitherto attempted. Not only will every trade, industry and art be represented on generous lines, but all branches of Science too will have their full share of attention. Each Department of this huge undertaking is being organised by a Committee of experts, and for this purpose the best brains in the British Empire have been enlisted, and are now busily engaged in making this wonderful Exhibition a signal success.

Sir W. Napier Shaw, LL.D., Sc.D., F.R.S., who is Chairman of the Scientific Section is being ably assisted by Sir Joseph Petavel, K.B.E., D.Sc., F.R.S., Sir Humphrey Rolleston, K.C.B., M.A., M.D., F.R.C.P., Sir Anthony A. Bowlby, K.C.B., K.C.M.G., K.C.V.O., and many other well known members of the scientific world.

Some idea may be formed of the area The British Empire Exhibition will occupy when we say that, in two sections alone (Machinery and Industrial) the floor-space required is five times that of Olympia.

The primary object of the Exhibition is to stimulate trade, and every avenue which may help in this direction is being eagerly explored by responsible Committees.

From an educational standpoint this Exhibition will be of immense value, for it will help the Nation to understand better than ever before, the greatness of the Empire, and the vastness of its resources. It would be somewhat premature to say more than this at the moment, but we hope later on to enter fully into details of the Exhibits which immediately concern the Medical and Dental Professions.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—Will you allow me to point out several mistakes in your report of my lecture on Lord Lister on 8th November, 1922.

I have placed them in parallel columns as they will be easier to follow :—

I am reported to have said	*What I did say.*
"A Lambeth lying-in hospital at one time closing its doors when the death-rate from puerperal fever reached 25 per cent."	"A Lambeth lying-in hospital used to close its doors when the mortality from puerperal fever rose to alarming proportions; sometimes they reached 25 per cent."
"He could remember notices being posted advocating that the operation (ovariotomy) should be made illegal."	"He could remember thinking that the operation ought to be prohibited owing to its appalling mortality."
"The dissecting-room and post-mortem coat was used by the house-surgeon whilst assisting at operations."	It was used by two of the surgeons themselves at operations.
"To the discredit of St. Thomas's and the London Hospital be it said that they had tried antiseptics and had abandoned them."	"St. Thomas's and the London Hospitals" (a very different statement. I made no specific reference to the London Hospital.)
(Lister) "was a great believer in Pasteur."	"The whole of Lister's treatment was based upon the work of Pasteur."
"He at one time carried about with him three flasks containing urine," etc.	"He had three flasks of boiled urine which he carefully treasured for years, and personally removed first from Glasgow to Edinburgh and later from Edinburgh to London, carrying them upon his knees all the way in the train lest they should be damaged."
"He married Symes' daughter and with her a dowry of £100,000."	"It was generally believed she brought him a considerable fortune, and *I have heard it stated* it was £100,000." (This is of course hearsay evidence only; I know nothing of the facts).
"Lister, like Socrates, was a poor writer";	"I am not aware that Socrates ever wrote anything. What I meant to enforce was that Lister, like Socrates, influenced the world by mouth and action rather than by pen."
"The ribald youth at the top of the theatre greeted Lister's entrance by exclaiming, 'Let us spray,' for which he was summarily ejected."	He was not ejected. "Lister looked at him in pity, not in anger! but three years afterwards he died from general paralysis of the insane!"
"Anæsthetics, which in his day were in their earliest infancy, were regarded as somewhat old-womanish."	I am at a loss to understand what is meant by "old-womanish." I never used the words, and the implication is purely gratuitous.
"In speaking of vivisection he said that there was more cruelty committed in an afternoon on a gentleman's shoot than in a month on the dissecting-room table."	"There is more cruelty in one afternoon of My Lord So-and-So's shooting than there is in the vivisection in this country in a whole year."

I am sorry to trouble you at such length, but I cannot allow such misleading statements to pass uncorrected; it was a great privilege to me to have the opportunity of bringing some details of the work of the immortal Lister before the members of Guy's Physical Society.—Yours faithfully,

J. R. LEESON.

Twickenham,
11th December, 1922.

[We apologize to Dr. Leeson for these inaccuracies.—Ed.]

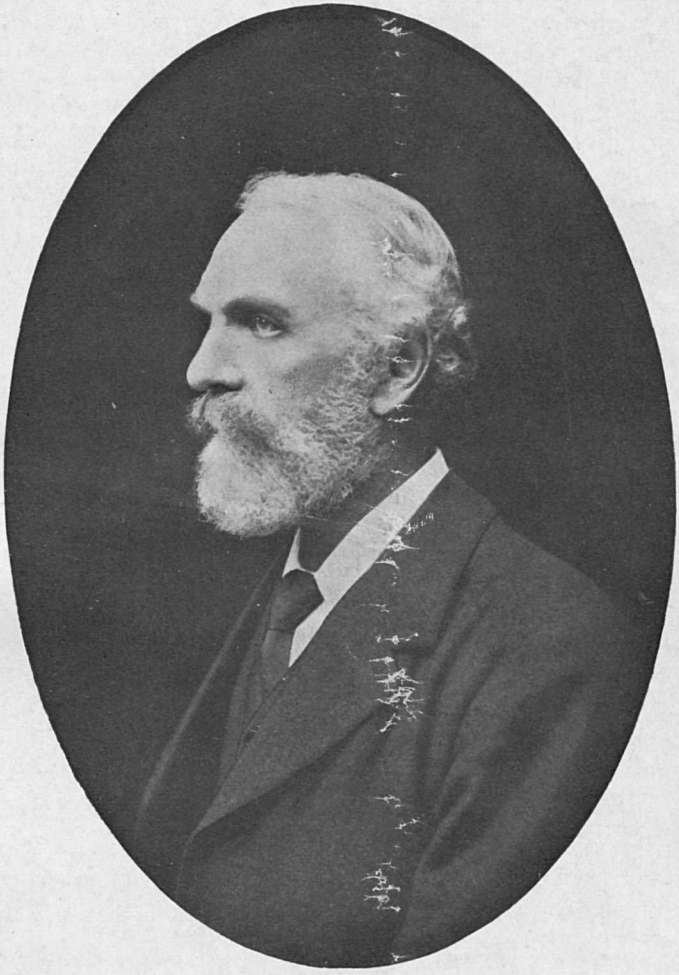
Guy's Hospital War Memorial Fund.

DEAR SIR,—I enclose herewith a further list of subscriptions received towards the Guy's War Memorial Fund, which I shall be glad if you will kindly publish in the next issue of the GAZETTE. I should also be grateful if you would allow me to use your columns for a further appeal for subscriptions to this Fund.

The Fund needs a further £150, to carry out the schemes already approved, owing to the fact that the cost of the War Memorial Arch exceeded the original estimate and the amount set aside by about £300. The Executive Committee are anxious to close the Fund at the earliest opportunity, and the assistance of all Guy's men is asked in order to raise this deficit. I am sure there should be no difficulty in raising this small amount if everybody co-operated and sent a small subscription to the undersigned.—I am, Yours faithfully,

M. S. PEMBREY,
Hon. Secretary,
Guy's Hospital War Memorial Fund.

Medical School,
Guy's Hospital, London, S.E.
December 14th, 1922.



REGINALD JOHN RYLE, M.D.Oxon., J.P.

GUY'S HOSPITAL WAR MEMORIAL.

Subscriptions received from December 1st, 1921, to December 15th, 1922.

	£	s.	d.
Amount already acknowledged ...	5,344	0	4
Dawson, General Veysey	1	0	0
Willan, G. T.	1	0	0
James, Mrs. J. (Final Instalment) ...	8	8	0
Dymott, V.	2	2	0
Gull, Sir Cameron (Second Instalment)	20	0	0
Lucas, H.	0	10	6
Churchill, Major Brooke	1	0	0
Bamber, H. E.	0	10	0
Newton, Miss M.	0	7	0
Howe, J. Duncan (Second Subscription)	1	0	0
Read, Mrs. L. B.	1	0	0
Elphick, Miss	0	10	0
Felton, R.	1	0	0
Colrun, M.	1	1	0
Henson, W. W.	1	1	0
Edney, C. H. (Sale of Guy's War Memorial Cards on Armistice Day)	6	1	0
Bulleid, W. A. (Fourth Instalment) ...	5	5	0
Anonymous	0	2	6
	£5,395	18	4

Notices.

Royal Medical Benevolent Fund Guild.

It has been decided to hold a Festival Dinner in aid of the above on January 30th, 1923, at the Hyde Park Hotel.

Tickets for Ladies and Gentlemen 17s. 6d. including wine. The names of the Chairman and Speakers will be announced later.

A meeting of the wives of the Members of the Staffs of the London Hospitals was held on November 28th, at 11, Chandos Street, in support of the Scheme, the object of which is to bring home to the Medical Profession and the General Public the urgent need both for increasing the Annual Subscriptions to the Royal Medical Benevolent Fund Guild and for raising a special fund for educational purposes.

Mrs. Kendal, who took the Chair at the preliminary meeting on November 28th, spoke of the high reputation which the Medical Profession enjoys for generosity. She had never known a doctor refuse assistance, though she had often known him refuse a fee. To that generosity the R.M.B.F. Guild must now appeal. Its needs are very pressing. In the past perhaps they have not been sufficiently made known. A doctor's work, from its nature, is dangerous. Those who succumb are often young men who have had no time in which to make the provision they desire for those who are dependent upon them. The Guild deals daily, and at present inadequately, with many hard cases among gentlewomen and children, unused to poverty, often ill-fitted to cope with it, yet called upon to bear it. Will any medical man who asks himself what might have been the consequences to his own family of his own early death fail to support this cause?

To the general public too, the appeal may be addressed with confidence. A rich man who by means of his doctor gains relief from suffering, and ill-health, a poor man who receives advice and treatment without fee, may both, on a different scale subscribe to a fund which combats poverty and ill-health among the dependents of men who have died in the service of the public.

Subscriptions to the Educational Fund should be sent to any one of the following ladies, who have kindly consented to act as Stewards for the Dinner, not later than January 20th.

Additional names of those willing to act as Stewards (i.e. collect £10 and upwards towards this fund) will be most gratefully received and announced in subsequent notices of the Dinner.

Applications for tickets for the Festival Dinner should be sent to the Secretaries:—

Miss Swinford Edwards, 68, Grosvenor St., W.1.
Miss Morley Fletcher, 98, Harley St., W.1.

Medical Aid Committee for Sufferers from the Russian Famine.

We have received the following letter from Dr. Haden Guest:—

Dear Sir,—

In forwarding you the enclosed copy of Dr. Nansen's Appeal I should be glad if you could assist us in getting publicity for it, in obtaining signatures, and in collecting contributions in money or in kind for the purposes of Medical Relief. My Committee was formed prior to the issue of the enclosed appeal by Dr. Nansen and, by arrangement with Dr. Nansen's Committee, has taken over the functions of Medical Relief Committee for this country.

Dr. Nansen's appeal is, as you will see, directed primarily to Medical and Allied Organisations and to men and women belonging to the professions they represent. But it is also our intention to issue an appeal to the general public in which I hope we may also have your co-operation.

Yours faithfully,

L. HADEN GUEST.

APPEAL FOR MEDICAL AID FOR RUSSIA FROM DR. NANSEN'S COMMITTEE.

To the Scientists and Medical Men of the World.

Following on the Great War, the Civil War and the long blockade, Russia has passed through a famine the like of which has not been known for centuries. One-third of the vast area of Russia is affected by the famine, a population of thirty-five million is stricken, and death has carried away millions of victims. Famine has wiped out both rural and urban populations; the peasants—the producers of grain for the world market—have died; whole nations, inhabiting the stricken regions have vanished and children, the hope of the future, have died out elsewhere. The horrors of famine have driven the inhabitants to fly, leaving their homes, deserting their cattle and fields. Whole villages have been ruined, the households left without furniture and without cattle. Factories are idle; the number of unemployed is growing, thousands of children have been left homeless.

Russian medical personnel, being cut off from the rest of the world in remote villages and townlets, amidst thousands of sick and starving people, has been quite helpless in this great calamity; yet they have heroically borne their burden and carried out their duty despite the imminent danger of death. Infirmaries, and in particular Emergency Medical Treatment Centres, organised with great effort, have had to be closed down owing to the lack of drugs and medical stores, and thus the struggle with the effects of famine is left entirely to the Russian medical personnel themselves. The exhausted and weak population of the affected regions fall easy victims to all kinds of epidemics which threaten not only Russia, but the whole of Europe.

The lives not only of the present generation, but of those of the future, are in danger.

The necessity of immediate and energetic aid is imperative. But Russia by herself is powerless.

We therefore appeal in the name of humanity and international solidarity, to the Scientific World of Europe and America, and we are sure that our appeal will meet with a generous response from the scientists and medical men of the world.

The sanitary and biological effects of the famine will be felt for a long time to come and not only in Russia, but in Europe as well. The Russian famine confronts the Scientific World as an exceptional sanitary and biological problem for the solution of which all the forces of science and medicine need to be concentrated.

And how should this assistance be given?

In every country, in each division of the country and in all the larger centres, a Committee of Medical Relief to fight the effects of the famine in Russia, should now be organised.

All the medical committees should be united in an International Committee for medical aid to fight the effects of the famine in Russia, under the presidency of Dr. Nansen.

The programme of the work of the International fight against the consequences of the famine must comprise :—

1. A well-directed agitation for the recognition of the Russian famine as an International sanitary and biological calamity.
2. Appeals to Governments.
3. To the people of the different countries.
4. Appeals to the scientific and medical workers of the whole world.
5. The collection of money.
6. The organisation of help in the way of medical equipment, medicines and sanitary articles, and means for organising medical institutions in the affected areas, as well as
7. The scientific study of famine from the sanitary and biological aspect.

The principle of international scientific and medical solidarity was a fairly well-established achievement of the pre-war period. Now, after the terrible world war, which has led to a number of grave social catastrophes and calamities, including the Russian famine, that solidarity must come again into active existence.

Science at the British Empire Exhibition.

STUDY OF TROPICAL DISEASES.

It is hoped that the Scientific Section of the British Empire Exhibition will be more completely representative than similar sections at any previous Exhibition. Various Scientific Societies are co-operating to make it a big success.

One of the departments in which the Oversea Dominions are particularly interested is that devoted to the study of tropical diseases, in which research and education are likely to be of immense value, not only in the saving of human life, but in the betterment of industry and horticulture.

Major Belcher, Assistant General Manager of the Exhibition, and head of the Empire Mission, paid a visit, when in New Zealand, to the Cawthorn Institute. Dr. Tillyard, whom he interviewed, was greatly interested in this section of the Exhibition, and offered to send an exhibit completely representative of his research in connection with the Woolly Aphis in New Zealand orchards.

This suggestion has been brought to the notice of the Tropical Diseases Committee, who have unanimously decided to take advantage of the offer.

Birth.

PEARCE.—On December 13th, 1922, at 24, Queen's Road, St. John's Wood, to Frank J. and Phyllis C. Pearce (née Verden) a daughter, Diana Mary.

ED.—J. A. C.